Dermatology & Dermatologic Surgery Group of Northern Virginia, PLLC

Patient Authorization for Practice to Release Protected Health Information (Medical Records Release)

Patient name (Printed)_____
Date of Birth_____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

What medical information are you requesting?

_____
_____
_____

How will this information be used?

_____
_____
_____

Who is requesting this information?

_____

Who will receive and use the disclosed information?

_____

Expiration date of this authorization: _____

The above-mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. By signing this form, you authorize the Practice to use and disclose PHI about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

Patient's signature_____

Date of request_____

_____

If you are not the patient and are requesting PHI

Signature_____

Print name_____

For PHI requested for patients 18 years of age or older by a representative other than the patient themselves, written legal power of attorney for the patient and a photo id of the representative must be presented before information can be released.