DERMATOLOGY, P.C.
6000 University Ave, Suite 450
West Des Moines, IA 50266
FAX (515) 241-2005

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

****** THIS FORM MUST BE COMPLETED IN FULL OR IT WILL DELAY YOUR REQUEST ******

Patient name:_____ **Date of Birth**:_____
***By signing this authorization, I authorize DERMATOLOGY, P.C. to use and/or disclose certain protected health information (PHI) about me to, or for the party or parties listed below.

Name:_____

Address:_____

City/State/Zip Code: _____

This authorization permits DERMATOLOGY, P.C. to use or disclose to the party/parties listed above the following individually identifiable health information: (e.g. dates seen, medical record, progress notes, pathology reports)

_____

** if not specified, information released under Dermatology, P.C. policies and associated legal guideline

I understand that I have the right to inspect the disclosed information at any time. This authorization will expire 60 calendar days from the signature date.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient as shown above and may no longer be protected by the federal HIPAA privacy Rule. I have the right to revoke this authorization except to the extent that DERMATOLOGY, P.C. has acted in reliance upon this authorization for record release prior to my written revocation. My written revocation of this authorization must be submitted to:

DERMATOLOGY, P.C., PRIVACY OFFICER, 6000 UNIVERSITY AVE, SUITE 450
WEST DES MOINES, IA 50266

Please specify the reason for the release of these medical records:
_____ Transferring medical care _____ Insurance
_____ Dissatisfied with care _____ Other_____

SPECIFIC AUTHORIZATION FOR THE RELEASE OF RECORDS PROTECTED BY STATE/FEDERAL LAW
I specifically authorize the release of medical records relating to: (please check the appropriate box)

❑ Yes Substance Abuse	□ Yes Mental Health	□ Yes HIV-related information
❑ No	□ No	□ No

** This information has been disclosed to you from records protected by federal confidentiality rules for alcohol/drug abuse records (42 CFR part 2), state law for mental health records, (Iowa Code Ch.228), and/or for HIV records (Iowa Code Ch.141). These rules/laws prohibit you from further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise allowed by law. A general authorization for release of medical or other information is insufficient for this purpose. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of this information. The federal rules pertaining to alcohol/drug abuse records restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Signature of patient or legal guardian_____ Date _____

_____

Print name Signature Relationship Date

_____

Address City State Zip Code

Initials (DPC employee)_____