**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 form, I authorize Dermatology P.C. to release my individual health information as determined below. I acknowledge that this authorization is voluntary and understand that if the organization receiving this information us not a health care provider this information may no longer be protected by federal privacy regulations.

**Authorizes:** (Please select one of the following)

☐ **DERMATOLOGY P.C.**
6000 University Ave, Suite 450
West Des Moines, IA 50266

☐ **DERMATOLOGY P.C.**
800 East 1st St. Suite 2900
Ankeny, IA 50021

☐ **DERMATOLOGY P.C.**
2006 North 4th St. Suite 100
Indianola, IA 50125

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 of Clinic/ Business:** ______________________________
**Provider Name:** ______________________________
**Address:**______________________________
**City/State/Zip Code:** ______________________________
**Phone Number:**______________________ **Fax Number:**______________________

This authorization permits **DERMATOLOGY P.C.** to release the following information, (Please select from the following, * if not specified, information released under Dermatology, P.C. policies and associated legal guideline):

**Release records from time period of ________to_________ (if left blank only the past 2 years will be disclosed) __Office Visit Summaries __Lab Reports __Procedure Reports**

SPECIFIC AUTHORIZATION FOR THE RELEASE OF RECORDS PROTECTED BY STATE AND 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.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 ___________

Please specify the reason for the release of these medical records:

**___Transferring medical care ___Insurance ___Legal ___Personal**
**___Continued Care ___Dissatisfied with Care ___Other (Describe):** ______________________

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

______________________________________________________________

Signature of patient or legal guardian Relationship Date

______________________________________________________________

Address City State Zip Code