Authorization for the Use or Disclosure of Protected Health Information

DAKOTA DERMATOLOGY
4950 S. Minnesota Avenue
Sioux Falls, SD 57108
Phone (605) 330-9619 Fax (605) 330-9503

As required by the Health insurance Portability and Accountability Act of 1996 DAKOTA DERMATOLOGY may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION SECTION ***(Please Print)***

I, _____hereby authorize the use and disclosure of the following health information that pertains to me.

Medical Records, Pathology, Lab, Slides

for the following purpose:

Continued Health Care, Personal, Other _____ Dates of Service _____

I authorize the following persons to ***make*** these disclosures of my health information:

Provider Name:_____ Facility:_____

Address:_____City, State, Zip:_____

Phone: _____Fax: _____

I authorize the following persons to ***receive*** these disclosures of my health information:

Provider Name:_____ Facility:_____

Address:_____City, State, Zip:_____

Phone: _____Fax: _____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to DAKOTA DERMATOLOGY. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire ONE year if not designated earlier. _____
Expiration

I understand that I have a right to inspect and obtain a copy of any information disclosed pursuant to this authorization.

I understand that DAKOTA DERMATOLOGY will receive compensation for the uses and disclosures that I have authorized.

_____ _____ _____
PATIENT NAME (Please Print) SS# Date of Birth

_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE