



Authorization to Disclose Protected Health Information

This authorization may be used to permit a covered entity to disclose an individual’s protected health information. Individuals completing this form should read its entirety before signing and completing all the sections that apply to their decisions relating to the disclosure of their protected health information and medical care.

Patient for Whom the Authorization is Made:

Full Name: _____ Date of Birth: _____ Phone: _____

Preferred Name: _____ Email: _____

Mailing Address: _____ Apt/Suite # _____

City: _____ State: _____ Zip Code: _____

Health Care Provider/Practice to Whom the Release is Made:

Practice: Wiregrass Dermatology | Provider: _____

Address: 3400 Ross Clark Circle, Dothan, AL 36303

Phone: (334) 679-7974 | Fax: (334) 305-2199 | Email: WiregrassDermAL@gmail.com

Health Care Provider/Practice from Whom the Release is Made:

Provider/Practice Name: _____

Mailing Address: _____ Apt/Suite # _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Information to Be Released:

- Pathology Reports
- Lab Reports
- Office Notes
- Entire Record

Reason for release of intervention (Choose all that apply):

- Treatment/Continuing Medical Care
- Personal/Insurance Use

The individual signing this form agrees and acknowledges as follows:

(i) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my authorization of this disclosure.

(ii) Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specific date: Month: _____ Day: _____ Year: _____.

(iii) Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.



(iv) Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV-AIDS- RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate line below. In the event that the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein. _____ (initials)

(v) Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature of Patient or Legal Guardian _____ Date _____

If Legal Representative, relationship to patient: _____

Signature of Witness: _____ Date _____