Accent Dermatology and Laser Institute, PLLC

Authorization to Use or Disclose My Health Information To a Third Party

Date: _____

To: **Accent Dermatology and Laser Institute** Address: **400 Indiana St, Suite 390**

Phone: **303-463-9600** Fax: **303-403-9919**

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- ☐ **All my health information maintained by the above-named practice**
- ☐ **Biopsy Report(s)**
- ☐ **Lab Report(s)**
- ☐ **Consultation Report(s)**
- ☐ **Notes from other physicians or sources**
- ☐ **Medical History**
- ☐ **Treatments**
- ☐ **Medication(s)**
- ☐ **Surgical Procedures**

Include: ***(Indicate by Initialing)***

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

- ☐ **My health information relating to the following treatment or condition:** _____
- ☐ **My health information for the date(s):** _____
- ☐ **Other:** _____

You may disclose this health information

To: _____ **Relationship:** _____

Name (or title) and organization: _____ **Phone:** _____ **Fax:** _____

Address: _____ **City**: _____ State_____ **Zip:**_____

This authorization ends:

- ☐ on (date) _____
- ☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.
- I may revoke this authorization in writing by writing a letter to the office. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.)