Accent Dermatology and Laser Institute, PLLC

Authorization to Use or Disclose My Health Information

Date: _____

To: _____ Address: _____

Phone: _____ Fax: _____

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)**	☐ **Medical History**	**Include: *(Indicate by Initialing)***
☐ **Lab Report(s)**	☐ **Treatments**	**_____ Alcohol/Drug Treatment**
☐ **Consultation Report(s)**	☐ **Medication(s)**	**_____ Mental Health Information**
☐ **Notes from other physicians or sources**	☐ **Surgical Procedures**	**_____ 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:

☐ **Dr. Kathleen Sawada** ☐ **Dr. Stephen Huang** ☐ **Accent Dermatology & Laser Institute Provider**

Name (or title) and organization: **Accent Dermatology and Laser Institute** Phone: **303-463-9600** Fax: **303-403-9919**

Address: **400 Indiana St. #390** City: **Golden** State: **CO** ZIP: **80401**

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.)