AUTHORIZATION FOR PHI REQUEST

Patient's Name: _____
Last First Middle Initial

By signing this authorization, I authorize: _____(sender)
Physician or Medical Institution

at _____

_____
City State Zip Code

to use and/or disclose certain **protected health information** (PHI) about me to the party listed below (recipient):

American Institute of Dermatology, P.A.

3109 Medical Way
Sebring, FL 33870-5548

Tel #: (863)386-0786
Fax #: (863)386-1848

This authorization permits the sender to use or disclose to the recipient the following individually identifiable health information by the following methods:

IIHI	PATIENT INITIALS		METHOD OF RELEASE	PATIENT INITIALS
Pathology Reports			Any of the methods below: Telephone, Fax, Mail, E-Mail & Hand-Delivered	
Bloodwork				
Progress Notes				
Entire Record and: HIV, Drugs/Substances Abuse, Sexually Transmitted Diseases & Mental Illnesses				
			Other (Specify)	
List any exclusions:			List any exclusions:	

This authorization will **not** expire unless a date is specified: _____ / _____ / _____.
Month Day Year

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the sender has acted in reliance upon this authorization. My written revocation must be submitted to the sender's Privacy Officer. I agree that a copy of this authorization may be considered as valid as the original.

_____ _____
Signature of Patient or Legal Guardian Date

OFFICE USE ONLY	DATE RECEIVED		EMPLOYEE INITIALS	