AUTHORIZATION FOR PHI RELEASE

Patient's Name: _____
Last Name First Name Middle Initial

By signing this authorization, I authorize *American Institute of Dermatology, P.A.* (sender) to use and/or disclose certain **protected health information** (PHI) about me (patient) to or for the party or parties listed below:

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

Tel: ( )_____ Fax: ( )_____ Tel: ( )_____ Fax: ( )_____

Email: _____ Email: _____

This authorization permits the sender to use or disclose to the above party or parties (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, & 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 at 3109 Medical Way, Sebring, FL 33870. 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 RELEASED		EMPLOYEE INITIALS	