TUCSON DERMATOLOGY

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Under the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Tucson Dermatology must have prior authorization to discuss your condition with, or to release any of your medical or billing information to members of your family or other individuals that you designate. If you wish to provide authorization to release your medical or billing information to others you must complete and sign this form. Signing this form will only allow information to be given to the individual(s) indicated below.

I authorize Tucson Dermatology, Ltd to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

4. _____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any recipient listed above is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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