

Lupton Dermatology
1587 Yanceyville Street
Greensboro, NC 27405
(336) 271-2777 • (336) 273-1910 - fax

Authorization to Use or Disclose Health Information

Patient Name: _____ **Date of Birth:** _____
Please print full name

1. I authorize the use or disclosure of the above named individual's health information by The Skin Surgery Center as described below.

2. **The type of information to be used or disclosed is as follows:**

My complete medical records **or** check the appropriate boxes below,

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Clinic Note | <input type="checkbox"/> Progress Note | <input type="checkbox"/> Anesthesia/Sedation Record | <input type="checkbox"/> Other (Specify below): |
| <input type="checkbox"/> Prescription History | <input type="checkbox"/> Consultation Note | <input type="checkbox"/> Bill for Service | |
| <input type="checkbox"/> Laboratory Result | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> History and Physical Report | |
| <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Paper copies of records (otherwise records will be on disc) | |

The above information can be released from the date of _____ through _____
Or the period of time encompassing all dates of service at The Skin Surgery Center.

3. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

4. The information identified above may be used or disclosed to the following individual(s) or organization(s):

Name of Organization or Individual

Address

Phone Number

Fax Number

5. This information for which I am authorizing disclosure will be used for the following purpose:

- my personal use sharing with other health care providers workman's compensation
 other: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. **This authorization will expire on** _____ (Date) or is valid as long as I am a patient of this practice. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

8. I understand that once the above information is disclosed, the recipient may redisclose it, and the federal privacy laws or regulations may not protect the information.

9. I understand the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

Signature of patient or legal representative

Date

If signed by legal representative, relationship to patient

Signature of witness

Date