DERMATOLOGY ASSOCIATES

WESTLAKE VILLAGE · MALIBU

Authorization for Disclosure of Health Information

Completion of this document authorizes the disclosure and use of health information about you, the patient. Failure to provide all information requested may invalidate this authorization.

Patient Information:

First Name: _____ Last Name: _____

Address: _____ City: _____ State:_____Zip:_____

Date of Birth: ___/___/___ Phone Number: (___)_____-_____

Authorizes:

_____

(Persons/Organizations Authorized to Receive the information)

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (___) _____ Fax Number: (___) _____

Information to be released:

___Office Visits

___Diagnostic Test results

___Operative Reports

___ Other Describe:_____

Purpose of requested use or disclosure: (check all that apply)

___Continued Care

___Insurance

___ Legal

___Second Opinion

___Other

My Rights:

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: Dermatology Associates of Westlake Village, 1240 S. Westlake Blvd, Ste. 205 Westlake Village, CA 91361.

My revocation will be effective upon receipt, but will not be effective to the extent that others have acted in reliance upon this Authorization.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless specifically required or permitted by law.

I understand I am entitled to receive a copy of this Authorization.

I hereby release my Provider, their associates, employees and agents from any liability following the release of this information. I agree that a photograph or faxed copy of this authorization shall be valid as the original.

Signature of Patient/ Legal Representative: _____

Date: _____

If signed by a person other than the patient, indicate relationship: _____

Print Name: _____

(Legal Representative)

Phone Number: (___) _____

*Legal representative must bring valid ID and proof of authority to act on behalf of patient.