DERMATOLOGY ASSOCIATES OF ROCHESTER
100 White Spruce Boulevard
Rochester, NY 14623
(P) 585-272-0700
(F) 585-272-8356

Patient Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

I authorize Dermatology Associates of Rochester to: **[ ] RELEASE** information to
[ ] OBTAIN information from

Name of Provider: _____

Address: _____

Phone: _____ Fax: _____

Information to disclose:
[ ] COMPLETE MEDICAL RECORD
[ ] Biopsy Report(s)
[ ] Lab Report(s)
[ ] Surgical procedure(s)
[ ] Other:_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

1. I understand that my right to receive healthcare treatment is not conditioned on my signing this authorization, provided, however, that Dermatology Associate of Rochester will notify me if it requires certain information to safely treat me. Signing is voluntary, however if I refuse to sign Dermatology Associates of Rochester will not release my records.
2. I may revoke this authorization at any time by submitting a written request to Dermatology Associates of Rochester, except where disclosure has already been made based on this authorization.
3. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in Item 4 above) and redisclosure may no longer be protected by federal or state law.
4. This authorization will remain in effect for 1 year from the date of my signature below unless I indicate a sooner expiration date here (enter date): ____/____/____ .
5. Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.
6. By specifically authorizing the release of sensitive information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of sensitive information, I may contact the New York State Division of Human Rights 1-888-392-3644.
7. Lastly, I understand that releasing and/or obtaining my records may take up to 30 days to complete.

_____

Signature of patient or legal representative Date

_____

Name of legal representative Relationship to patient

****Office use only: Date Rec'd: _____ Date Sent: _____ Staff Initials: _____