

# Authorization for the Use or Disclosure of Protected Health Information

DAKOTA DERMATOLOGY  
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As required by the Health insurance Portability and Accountability Act of 1996 DAKOTA DERMATOLOGY may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

## AUTHORIZATION SECTION *(Please Print)*

I, \_\_\_\_\_ hereby authorize the use and disclosure of the following health information that pertains to me.

Medical Records, Pathology, Lab, Slides

for the following purpose:

Continued Health Care, Personal, Other \_\_\_\_\_

I authorize the following persons to make these disclosures of my health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize the following persons to receive these disclosures of my health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to DAKOTA DERMATOLOGY. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire ONE year if not designated earlier. \_\_\_\_\_  
Expiration

I understand that I have a right to inspect and obtain a copy of any information disclosed pursuant to this authorization.

I understand that DAKOTA DERMATOLOGY will receive compensation for the uses and disclosures that I have authorized.

\_\_\_\_\_  
PATIENT NAME (Please Print)

\_\_\_\_\_  
SS#

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
DATE

**DISCLAIMER:** The information provided in this document does not constitute, and is no substitute for, legal or other professional advice. Users should consult their own legal or other professional advisors for individualized guidance regarding the application of the law to their particular situations, and in connection with other compliance-related concerns.