THE DERMATOLOGY CENTER OF INDIANA

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LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Entity Requested to Release Information:
Dermatology Center of Indiana
1100 Southfield Dr #1240 Plainfield, IN 46168
Phone: 317-838-9911 Fax: 317-837-6080

Purpose of Request *(who will be authorized to receive information)*
I authorize the entity identified above to disclose or provide protected health information, about me, to

Name:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Description of information to be disclosed
I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ☐ Entire patient record

or, check only those items of the record to be disclosed:

- ☐ Office Notes ☐ Lab results ☐ X-rays
- ☐ Hospital, nursing home, home health, hospice, and other physician records
- ☐ Record of HIV and communicable disease testing
- ☐ Record of mental health or substance abuse treatment
- ☐ Only send the following:_____

Purpose of disclosure *(please describe the purpose of the disclosure or check patient request)*:

- ☐ Patient Request ☐ Other (please specify):_____

Expirations of termination of authorization: This authorization will expire at the end of the calendar year in which it was signed, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.
Please list date of expiration if earlier than end of calendar year:_____

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.
Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
Disclosure: We have no control over the entities or person(s) you have listed to receive your protected health information (PHI). Therefore, your PHI disclosed under this authorization will no longer be the responsibility of the practice releasing the PHI and, depending upon the entity receiving it, may no longer be protected by the requirements of the Privacy Rule.

Patient signature_____ **Date**_____