EL CENTRO DERMATOLOGY & LASER CENTER

HIPAA Compliant PHI Release Form

Authorization for Disclosure of Protected Health Information

I, _____, authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I. I authorize the following person(s) and/or organization(s) to disclose my protected health information as specified:
   a. Name(s):_____
   b. Organization(s):_____
   c. Address:_____

II. I authorize the following person(s) and/or organization(s) to receive my protected health information as disclosed by the person(s) and/or organization(s) above.

III. Specific description of the protected health information that I authorize for disclosure: Treatment notes, diagnostic test results, history/physical notes, narrative reports, billing data.

IV. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) an/or organization(s) named above have taken action in reliance on this authorization.

V. I understand that the information released may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as: hepatitis, syphilis, gonorrhea and the Human Immune Deficiency Virus also known as Acquired Immune Deficiency Syndrome (AIDS).

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Signed: _____ Date: _____
Name: _____ DOB: _____
Address: _____
Telephone: _____ Social Security No. _____
Relationship or authority of representative (if applicable): _____