PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) - IRONWOOD DERMATOLOGY

Name: ______________________________ D.O.B.: ___________ Phone#:____________

I hereby authorize ____to release the following information contained in my medical records for the period from: START DATE_________________________ to ________________________(END DATE).

☐ All PHI including confidential ☐ All PHI except confidential selected below *

*(*Note: While specific Confidential PHI will not be included, the information authorized for release may make reference to confidential findings.)*

Confidential : ☐ HIV Test Results ☐ Alcohol & Drug Therapy ☐ Mental Health Treatment Records
☐ Clinic Notes for Doctors ☐ Lab Reports ☐ X-ray reports ☐Other_________________

Release of PHI is for: ☐ Attorney ☐ Doctor ☐ Insurance ☐ Other _________________

Mail to:
☐ IRONWOOD DERMATOLOGY, P.C.
1735 E SKYLINE DRIVE
TUCSON, ARIZONA 85718
520-618-1630 Fax 520-618-1636

Other (Name & Address):
☐ __________________________________
____
____
____

This is: ☐ A One-time Disclosure ☐ A Continuing Disclosure for 12 Months

Please allow 10 business days for records to be processed and ready.

I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breech of my right to confidentiality.

__________________________________ __________________________________

Signature Relationship to Patient (if applicable)

__________________________________ __________________________________

Signature of Witness (if needed) Date

The employee receiving this revocation must fill out the following information and then place the signed original in the designated place in patient's chart under the Authorizations tab.

__________________________________ __________________________________

Signature of employee receiving revocation Date received