CONTEMPORARY & COSMETIC DERMATOLOGY, P.C.

Michele Grodberg, M.D. & Associates

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

TODAY'S DATE :_____ PATIENT'S FULL NAME:_____

DATE OF BIRTH:_____ CONTACT NUMBER:_____

I authorize Contemporary & Cosmetic Dermatology, P.C. to disclose the Protected Health Information described below to the following person(s) and/or entity (ies):

_____
Name

_____
Mailing Address

I authorize Contemporary & Cosmetic Dermatology, P.C. to disclose the following individually identifiable health information about me

(specifically describe the information to be used or disclosed, such as date(s) of service, types of services, level of detail to be released, origin of information, etc.)

_____

_____

Dates of care included from _____ to _____

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1. I understand that it may take at least 7 to 10 days to complete copies of medical records to be gathered.

2. The practice may charge $40.00 for additional requests for copies of records after the first request.

3. I understand that records from other medical facilities and/or doctors will NOT be included in this release unless specified.

4. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

5. I understand that Contemporary & Cosmetic Dermatology, P.C. will not condition treatment or payment on my providing authorization for the requested disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

6. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Contemporary & Cosmetic Dermatology, P.C. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, where other action has been taken in reliance on an authorization I have signed.

7. I understand that information used or disclosed pursuant to this authorization could be subject: to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

*EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now) _____. (If no date is stated, this authorization expires six months from the date it was signed.)

_____ _____ _____
DATE SIGNATURE OF PATIENT/REPRESENTATIVE IF NOT PATIENT STATE RELATIONSHIP