goodman DERMATOLOGY p.c.
Medical, Surgical, and Cosmetic Dermatology | Adult & Pediatric

Authorization for Release of Protected Health Information (PHI)

PATIENT INFORMATION

Patient Name: Date of Birth: Phone:

Address:

Email: Medical Record #:

INDIVIDUAL OR ENTITY TO RECEIVE INFORMATION

□ Self (Information above)

□ Individual or Entity
Name: _____Phone:_____Email: _____

Address: _____Fax: _____

PHI TO BE RELEASED

Treatment Date(s): □ **ALL Treatment Dates OR**
□ From _____ To _____ (please be specific)

□ **Entire Record OR**

□ Discharge summary □ Operative Report □ Laboratory Report(s) □ Pathology Report(s)
□ History and Physical □ Procedure Note(s) □ Dermatological Images in Photo Format □ Billing Records

FORMAT & METHOD OF DELIVERY

Format (select one as appropriate): □ Paper □ Fax □ Oral Communications

Delivery (select one as applicable): □ In-Person Pick up □ Mail □ Fax □Other:

PURPOSE OF REQUEST

□ Personal □ Insurance □ Continuation of Care □ Legal □ Other (specify):

REVIEW AND APPROVAL

I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases, and drug or alcohol abuse. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):

□ Mental and Behavioral Health □ Substance Abuse □ Genetic Testing

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, AQUA Dermatology and its affiliated brands will continue to provide treatment and seek payment for services provided. AQUA Dermatology may charge a fee for providing information specified above.

This Authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here: _____

Signature Printed Name Date

REPRESENTATIVE (complete if signed by patient representative)

Representative Full Name: Relationship to Patient:

If you are not the patient or the parent of a minor patient, you MUST include documentation of your authority to act on behalf of the patient (Power of Attorney, Court Order, Legal Guardianship Documentation, Executor/Administrator Documentation)