Cahaba Dermatology
skin health center
Vlada Groysman, MD, FAAD
2290 Valley Dale Rd, Suite 204, Hoover, AL 35244
Phone: 205.214.7546 Fax: 205.982.4141

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information (PHI) as described below. This authorization includes any information relating to drug and/or alcohol abuse/treatment. Communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer be protected by federal privacy regulations.

Patient Name: _____ _____

Medical Record Number: _____

Patient SSN: _____

Patient DOB: ____/____/_____

Patient's Phone:_____

Patient's Address: _____

City, State, Zip:_____

Persons/Organizations <u>providing</u> Medical Records:

Name:_____

Address:_____

City, State, Zip:_____

Phone:_____(fax)_____

Persons/Organizations <u>receiving</u> Medical Records:

Name:_____

Address:_____

City, State, Zip:_____

Phone:_____(fax) _____

<u>Specific description of Information:</u>

All Medical Records ___Pathology Reports ___Diagnostic Procedure Reports

___Lab Reports ___Medication Lists ___Clinic Notes

___Consultation Notes ___Problem List ___X-Ray Reports

<u>Purpose of Use or Disclosure:</u>

___My Personal Use ___Sharing with other health care providers as needed

___Other: (Please Describe)

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The patient or the patient's representative must read and initial the following statements:

I understand that if I revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the entity privacy coordinator. I understand that the revocation will not apply to information that has been already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Initial:_____ I understand that I may revoke this authorization at any time by notifying the Cahaba Dermatology Office Administrator in writing, but if I do, it will not have any effect to the extent Cahaba Dermatology took action in reliance on the authorization.

Initial:_____ I understand that Cahaba Dermatology may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this authorization, except under the following circumstances:

- Participating in research projects can be conditioned on my signing an authorization to use and disclose PHI in the research
- Initial enrollment in health plans can be conditioned on signing an authorization for the health plan to review PHI to make eligibility determinations
- Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment.
- This authorization will expire:_____.

(Date of Service)

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

Signature of patient or patient's representative: _____

Printed Name of patient:_____

Printed Name of patient's representative:_____

Relationship to the patient:_____

Date:_____