Dermatology Associates
Phone: 319-236-3444
1-800-245-6246

3812 Pheasant Lane
Waterloo, Iowa 50701
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Authorization for the Release of Confidential Health Information

I, ________________________________, hereby authorize Dermatology Associates to :
(Name of Patient or Authorized Agent)

______**release TO:** (and-or) _____**obtain FROM:**

____ _(____)_____-________
*(**Name** of Health Care Facility, Physician, Agency, etc.)* *(**Phone** Number)*

____ _(____)_____-________
*(Street **Address**, City, State and Zip Code)* *(Fax Number)*

The following information contained in the patient record of ______________________________
(Patient's Name)

Born __________, residing at ____:
(Birth date) *(Street Address, City, State and Zip Code)*

☐ The entire medical record, ***excluding*** mental health information/treatment, substance abuse information/treatment, and HIV/acquired immune deficiency syndrome (AIDS) records

including	☐ **YES**	☐ **NO**	Mental Health Treatment Records/Information
including	☐ **YES**	☐ **NO**	Substance Abuse Treatment Records/Information
including	☐ **YES**	☐ **NO**	HIV/Acquired Immune Deficiency Syndrome (AIDS) Records/Information

☐ Laboratory Reports

☐ X-ray Reports

☐ Operative Notes *including* Biopsy Reports

☐ Other: ____

The above information for the following period of time shall be released: from __________ to __________.
(Date) *(Date)*

The **purpose** of the authorization is: _____ At the request of the individual _____Continued care

Other:____.

- I understand this release provides Dermatology Associates the authorization to disclose and/or deliver, obtain or exchange, verbally or in writing, medical information
- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the Practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that in writing.
- I understand that I may revoke this authorization at any time by giving written notice to the Practice of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the Practice has already relied on it to use or disclose my health information. Written revocation must be sent to the Practice's office.
- Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate **1 year from today or on (Date)** ________________.

Signed: ______________________________________ **Date:** ______________

If you are not the patient, please specify your relationship to the patient: ______________________

New: 04/03
Revised: 06/07 01/11 05/11