DERMATOLOGY ASSOCIATES of GEORGIA

PATIENT AUTHORIZATION For USE And DISCLOSURE Of PROTECTED HEALTH INFORMATION

Patient Name: _____DOB: ____/____/____ Date: ____/____, 201____

By signing this authorization, I authorize DERMATOLOGY ASSOCIATES of GEORGIA, LLC to use and/or disclose certain protected health information (PHI) about me to: (list names of Parent(s), Guardian(s); Family members, Friends, or others to receive this information.)

_____ _____

_____ _____

_____ _____

This authorization permits DERMATOLOGY ASSOCIATES of GEORGIA, LLC to use and/or disclose the following identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, level of detail to be release, origin of information, etc.):

_____

_____

_____

If all, or no restrictions on PHI check ☐ x:

The information will be used or disclosed for the following purpose:

_____

If requested by the Patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire one year from date of signature.

Dermatology Associate s of Georgia, LLC *will not* receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I do not have to sign this authorization in order to receive treatment from Dermatology Associates of Georgia, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Dermatology Associates of Georgia, LLC has acted in reliance upon this authorization. *My written revocation must be submitted to the Privacy and Security Officer at: Dermatology Associates of Georgia, LLC - 1951 Clairmont Road, C/O Medical Records, Decatur, GA 30033*

Signed by: _____ Print Name: _____

Relationship to Patient: _____ Write in or Choose: *Spouse – Parent – Friend - Other*

Patient Name: _____ DOB: _____/_____/_____

Print Name of Patient or Legal Guardian: _____

Patient offered Form and Declined: Y__ N__ BY: Employee: _____(name)
Initial:_____

Internal Use only: FOR ALL PATIENTS- For Updating
Scanned: __ /__/20___ By:

/DSM Compliance/HIPAA PTN AUTH PHI HIPAA 6-25-18