APDerm®
ADULT & PEDIATRIC DERMATOLOGY

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Permission to share your health information

A. PATIENT INFORMATION

Patient Name: _____ **Date of Birth**: _____/_____/_____(mm/dd/yyyy)

Address: _____ **Preferred Telephone**: _____ -_____-_____
(Street)

_____ _____
(City/Town) (State) (Zip)

B. PERMISSION TO SHARE: I give Adult & Pediatric Dermatology, PC permission to share my protected health information with:

☐ Check here if you are sending the records to yourself at the above address.

Name: _____ **Telephone**: _____ -_____-_____

Address: _____ **Fax**: _____ -_____-_____
(Street)

_____
(City/Town) (State) (Zip)

C. PURPOSE:

☐ Primary Care Physician ☐ Transfer of Care ☐ Disability ☐ Life Insurance
☐ Myself Reason (circle): Moving Dissatisfied ☐ Other (please specify): _____
Insurance Change Other _____

D. INFORMATION TO BE RELEASED: (we will only release records belonging to the office listed above)

Treatment dates from _____/_____/_____ through _____/_____/_____

Type of information to share:

☐ Clinical Records ☐ Surgical Procedure ☐ Lab Reports ☐ Photographs
☐ Billing Records ☐ Pathology Reports ☐ Other (please specify) _____

E. PRIVILEGED OR SPECIFICALLY PROTECTED INFORMATION: Please check YES if you give permission to release the following information if it exists in your records:

☐ Yes Alcohol or Drug Abuse Treatment
☐ Yes HIV / AIDS diagnosis and/or treatment
☐ Yes Sexually Transmitted Diseases
☐ Yes Behavioral Health Diagnosis
☐ Yes Domestic Violence Victim's Counseling
☐ Yes Sexual Assault Victim's Counseling
☐ Yes Genetics Screening Testing results

F. I UNDERSTAND AND AGREE THAT:

- This authorization will expire in 12 months from the date it is signed unless a date or event is listed: _____
- This authorization is voluntary, and my medical care will not be affected if I do not sign this form
- The information that I authorize for release may be re-disclosed by the recipient and no longer protected by federal privacy regulations
- I may revoke or cancel this authorization at any time by presenting a written request to the practice where I receive care except to the extent that my authorization has already relied upon my authorization
- I have read this form and I had the opportunity to have my questions about this form answered

Signature of Patient/Legal Representative: _____ **Date:** _____

Print Name: _____ **Legal Representative Relationship to Patient:** _____

Please mail or fax to: Medical Records 526 Main Street Suite 302, Acton, MA 01720 Fax: 978.849.7558