AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: __________________________ Date of Birth: _________________

Release FROM or TO: Name: ____

Address: _________________________________Phone:_____________ Fax: _____________

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following: **Mays Dermatology & Cosmetic Center**

241 Sears Ave, Ste 103, Louisville, KY 40207, Phone: 502-384-6544, Fax: 1-855-653-6155

Information authorized for use of disclosure or to be obtained:

€ All medical information concerning this patient
€ Medical Information of this patient complied between __________ to ___________
€ Only (specify):__________________________

The information obtained will be used for the following purpose(s) only:

____Insurance _____Continued Treatment ____Legal ____ Request of the patient/representative ____Other

I understand the following:

- I may revoke this authorization at any time, in writing, expect revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to healthcare provider's privacy office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature.
- I release the entities listed above, their agents and employees from liability in connection with the use or disclosure of the protected health information protected by this authorization. The entity authorized to disclose the information will not be compensated by the recipient of the disclosure. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements.
- I have the right to inspect the health information to be released and may refuse to sign this authorization.

I understand that my medical information may indicate that I have communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric or substance abuse.

_____________________________________ ________________________

Signature of patient Date

_____________________________________ ___________________________

Description of Legal Representative's Authority Expiration date of Authorization