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PATIENT AUTHORIZATION

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Silver Falls Dermatology to use and/or disclose protected health information (PHI) about me to the provider/clinic listed below.

CLINIC/PROVIDER:	PHONE:	FAX:

This authorization permits Silver Falls Dermatology to use and/or disclose the following individually identifying health information about me:

☐ Medical records for continuity of care;
☐ Lab and pathology results;
☐ Diagnostic imaging reports;
☐ Allergen vials; or
☐ Please send my entire medical record (all information) to entity above. The recipient understands that this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

____ HIV/AIDS information
____ Mental health information
____ Genetic testing information
____ Alcohol/chemical dependency diagnosis, treatment or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal and/or state law may restrict disclosures of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require my authorization prior to redisclosure.

I do not have to sign this authorization in order to receive treatment from Silver Falls Dermatology. 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 redisclosure by the recipient and may no longer by protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 1793 13th Street SE, Salem, OR 97302.

Print Name Date of Birth

Signature of Patient or Legal Guardian Relationship to Patient Date