DERMATOLOGY, P.C.
6000 University Ave, Suite 450
West Des Moines, IA 50266
(515) 241-2000

LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name:_____

Social Security Number (last 4 digits): _____ **Date of Birth**: _____

Purpose of request (who will be authorized to receive information) – I authorize Dermatology, P.C. to disclose or provide protected health information (PHI) about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI) :

Individual/entity name: _____

Individuals Address:_____

City, State, Zip: _____Phone: (____)_____

Description of information to be disclosed – I authorize Dermatology, P.C. to disclose the following protected health information about me to the individual(s), entity identified above:

- ❑ Entire patient record; or, check only those items below of the record to be disclosed:
  - ❑ Office notes
  - ❑ Lab results, pathology reports
  - ❑ X-rays
  - ❑ Financial history report (previous 3 years only)
  - ❑ nursing home, home health, hospice, other physician records
  - ❑ record of HIV and communicable disease testing
  - ❑ record of mental health or substance abuse treatment
  - ❑ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check 'patient request')

❑ Patient request ❑ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last dated signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration **if earlier that the end of the calendar year**: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- Dermatology, P.C. places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of Dermatology, P.C.

_____ _____
Patient or representative signature Date

_____ _____
Patient or representative signature Date

_____ _____
Patient or representative signature Date

_____ _____
Patient or representative signature Date

(You have the right to receive a copy of signed authorizations upon request.)