108 Dornach Way, Advance, N.C. 27006
(T) 336-940-2407; (F) 336-940-2409

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH OR BILLING INFORMATION

Patient Information: I give permission to release the health information of:

Patient Name: ______________________________________ Date of Birth: ___________________
Street Address: _____________________________________ Last 4 numbers of SSN: ___________
City, State, Zip: _____________________________________ Telephone: _____________________

	Release Information from (Facility/Provider):	Release information to (Facility/Provider):
Name/ Facility		
Address		
Phone/ Fax		

(Check each appropriate items to release) Entire Record ______ Office notes ____Laboratory Reports______
Operative Report _______ Pathology Reports _____ Billing information ____ Medications _____

Format (Select 1)	Delivery Method (Select 1)
Paper Copy (charges may apply) ____ Electronic__	Mail _____ Pick up ___ Fax ____

Treatment dates (if certain dates are wanted) ________________This authorization will expire on ________

I understand that: Davie Dermatology will not share your health information except by ways listed in the "Notice of Privacy Practices" by Davie Dermatology. You may cancel this authorization at any time by submitting your request in writing to the Privacy Officer at Davie Dermatology. When your information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You do not have to sign this authorization in order to receive treatment from Davie Dermatology and The Med Spa.

Signed by: ____
Signature of Patient/Legal Guardian/Healthcare Agent/ POA/Parent

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. The relationship/authority if signature is not that of the patient (written proof may be requested)

___________________________________ __________________ _____________________
Name of Person Signing this form Relationship to Patient Date

Date of Birth __________ (If not patient signature, relationship to patient) ___________

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION.

For Office Use Only:
Date of Release _________________________ via Mail___ Fax___ Other___ ID verified __ DL/other ID___
DD Employee Name ____________________________________ Date _________________