

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Magnolia Dermatology and Aesthetics to use and/or disclose my protected health information as follows:

Dates of Disclosure: _____ to _____.

Information to be released:

- CHART NOTES.
- Referral/patient request/other: _____.
- LABS.
- PATHOLOGY REPORT.
- Other: _____ (please describe).
- All records generated by Magnolia Dermatology and Aesthetics.

Purposes for Release of Information:

- Release to another physician or health care institution (identified below).
- Information requested by Insurance Carrier.
- Continued Patient Care.
- For Patient's own records.
- Insurance Claim/Application.
- Other: _____ (please describe).

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by Magnolia Dermatology and Aesthetics and any provider/facility identified below. I have the right to request a copy of this Authorization. I may revoke this authorization at any time by notifying Magnolia Dermatology and Aesthetics in the manner set forth in the Notice of Privacy Practices. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire 1 year from the date signed.

I have signed this Authorization for the Use and Disclosure of Protected Health Information and hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient / Parent / Authorized Representative _____

Patient Name, Date of Birth _____

Date _____

Above listed patient authorizes the following healthcare facility to receive the record:

Magnolia Dermatology and Aesthetics
582 New Loudon Rd, Latham, NY 12110
Phone: 518-875-3376
Fax: 518-602-5012

Provider Name: _____
Address: _____
Phone: _____
Fax: _____

Please note: A copy fee of \$35 may be charged for the medical records.