WEGMAN DERMATOLOGY, PLLC

802 W KING ST, STE H
OWOSSO, MICHIGAN 48867
(PHONE) 989-723-8281 (FAX) 989-723-6846
*****AFTER HOURS*** 989-277-5240**

RECORDS RELEASE

Patient Authorization for Practice to Release Protected Health Information (PHI)

PATIENT:_____DOB:_____DATE:_____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

DESCRIPTION OF PHI BEING REQUESTED AND PURPOSE:

_____
_____
_____

INDIVIDUAL(S) WHO MAY DISCLOSE PHI:

_____

INDIVIDUAL(S) WHO MAY RECEIVE AND USE PHI:

_____

EXPIRATION OF THIS AUTHORIZATION: _____

The above-mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to the Practice.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice (*Patrick A. Wegman, II, Practice Manager of Wegman Dermatology, PLLC*).

PATIENT (REPRESENTATIVE) SIGNATURE: _____DATE: _____

WITNESS SIGNATURE:_____DATE:_____