DERMATOLOGY PARTNERS
of Western New York, LLP

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30 North Union Street, Suite 105 · Rochester, NY 14607 · (585) 232-8940 Phone · (585) 232-8687 Fax

AUTHORIZATION TO DISCLOSE PROTECTED INFORMATION

Date: _____

Patient Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

_____

☐I authorize Dermatology Partners to **RELEASE** information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone Number/Fax Number

☐I authorize Dermatology Partners to **OBTAIN** information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone Number/Fax Number

Information to be disclosed:

☐Complete Record ☐Most recent office notes ☐Pathology Reports
☐Laboratory Reports ☐Other _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information state above could be re-disclosed.
- The information may contain testing or treatment relating to sexually transmitted diseases.
- I understand that this authorization remains in effect for 30 days from the date of my signature below.
- I understand there may be a fee for copying my medical records if less than 12 months from last request.

The information on the above patient has been disclosed to you from records by NYS Public Health Section 17 & 18 HIPPA confidentially rules and regulations. Receiving entities are prohibited from further disclosure with out the written consent of the above named patient. A general authorization for release is needed for this purpose.

_____ _____
Name of Patient/Legal Representative Date

_____
Relationship