pure.dermatology

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Legal Name: _____ Date of Birth:_____
Address: _____ Phone: _____
City: _____ State: _____Zip:_____

I authorize: Pure Dermatology
Address: 2233 West Kagy Blvd., Suite 2 City: Bozeman State: Montana Zip: 59718
Fax: 406 586 2332 Phone: 406 586 7873

To disclose/release the Protected Health Information (PHI) of the patient listed above to:
Self: _____ Family Members: _____
Address (If different than above): _____
City: _____ State: _____ Zip: _____
Fax: _____

Person/Organization: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
Fax: _____

I Authorize _____ to pick up my Protected Health Information.

Purpose: ☐ Continuation of Care ☐ Personal ☐ Insurance ☐ Litigation ☐ Other: _____
Dates of Treatment: _____ Date Needed: _____

Pertinent PHI Information: ☐ Entire record ☐ Chart Note ☐ Pathology Reports ☐ Laser Log
Cosmetic Note ☐ Photos of: _____ ☐ Other: _____

ACKNOWLEDGEMENT: I request and authorize the above-named doctor or health care provider to release the information specified above to the organization, agency, or individual named on this request. I understand that the information to be released may include information regarding drug and alcohol abuse, communicable/infectious diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and psychological or psychiatric conditions, if any. I understand that if the receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy regulations and may be re disclosed.

EXPIRATION: Without my express revocation, this authorization will automatically expire one year from the date hereof, unless otherwise specified: Date to Expire_____ Do not Expire: _____ (initial)

REVOCATION: I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must submit a letter to the Director of Health Information Management.

OTHER CONDITIONS: A copy of this authorization with my signature may be used with the same effectiveness as an original. I understand that:
• If I do not sign this authorization, Teresa Mann, M.D., P.C. will still provide treatment and seek payment for services provided.
• Fees/charges will comply with all laws and regulations applicable to release of information.

Signature of Patient/Patient Representative: _____Date _____

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