Authorization to Disclose Protected Health Information

I authorize medical providers and personnel of Frontier Dermatology to discuss my appointment, care plan, and any other Protected Health Information including billing matters with the following people:

Name: _____

Home Phone: _____ Mobile Phone: _____

Relationship to Patient: _____

Name: _____

Home Phone: _____ Mobile Phone: _____

Relationship to Patient: _____

Name: _____

Home Phone: _____ Mobile Phone: _____

Relationship to Patient: _____

This authorization shall remain in effect for all past, present, and future periods unless revoked by a written notification.

I understand I have the right to revoke this authorization, in writing, at any time, except where we have already made disclosures in reliance on your prior consent.

I understand information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes of office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Patient Name **Patient Date of Birth**

_____ _____

Patient Signature (or Legal Guardian) **Date**

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