DERMATOLOGY ASSOCIATES, P.A.

FALLS M. HARRIS, M.D. • CHARLES S. WEST JR., M.D.
JOSEPH M. CATANZARO, M.D. • LESLIE HOWARD POINSETTE, M.D.
MATTHEW E. BRYAN, M.D. • JOEL C. PHILLIPS, M.D.
W. JUSTIN MCCRARY, M.D. • ALLYSON N. COOK, PA-C

28 MEDICAL RIDGE DRIVE
GREENVILLE, SC 29605
(864) 271-7440
FAX: (864) 271-6001

TheDermDocs.com

317 TANNER ROAD
GREENVILLE, SC 29607
(864) 627-8911
FAX: (864) 627-8294

Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize Dermatology Associates, P.A. and its designated staff members to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Dermatology Associates, P.A. to use or disclose to:

_____

_____

_____

❑ Complete Medical Record or only the following:

❑ Biopsy Reports
❑ Lab Reports
❑ Medication Allergies Allergy
❑ Surgical Procedures
❑ Office Notes
❑ Consultation Reports
❑ Test/Treatment
❑ Other _____

This protected health information is being used or disclosed for the following purposes:

_____

_____ or, ❑ at the request of the individual

This authorization will expire on _____

My physician will not condition my treatment, payment, enrollment in health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Dermatology Associates, P.A. has acted in reliance upon this authorization. My written revocation must be submitted to Dermatology Associates, P.A., 28 Medical Ridge Drive, Greenville, SC 29605.

_____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____
Print Name of Legal Guardian

_____ _____
Patient's Name | Date

_____ _____
Patient's Date of Birth | Patient's Social Security Number