ADVANCED DERMATOLOGY ASSOCIATES, LTD
1259 S. Cedar Crest Blvd, Suite 100
Allentown, PA 18103
610-437-4134 610-433-9690 (Fax)

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Disclosure of Protected Health Information

Authorization for Release of Medical Records

Patient Name:	Date of Birth:	Acct #:
Patient Address:	Telephone #:	Cellphone #:

I HEREBY AUTHORIZE ADVANCED DERMATOLOGY ASSOCIATES, LTD TO:

☐ **RELEASE TO:** **or** ☐ **RECEIVE FROM**:

Name of Person/Medical Provider or Facility: _____

Person/Medical Provider or Facility Address:	Telephone #
	Fax #:

Patient authorizes disclosure of the following protected health information:

A. ____My complete medical record for services provided on or after the following date _____

Unless this authorization is expressly limited by filling in Part B below, this authorization grants the Health Care Provider the right to release all personal medical information for the purposes described, including medical information about any diagnosis or treatment for any mental health, drug, alcohol or substance abuse condition, sexually transmitted diseases (such as HIV), cancer and the manifestation of and effects of a condition that happens to be genetic. It does not authorize the disclosure of any other genetic information, Substance Use Disorder patient records (§42CFR Part 2) or psychotherapy notes. ☐ All Records ☐ Pathology Reports ☐ Lab Reports ☐ Photos ☐ Other (please describe details) _____

B. ____ Release only the following medical information from my medical record: (Specifically describe the information to released, including, but not limited to, meaningful descriptors such as date of service, type of service performed, level of detail to be released, origin of information etc.) _____

_____

This information has been disclosed to you from records protected by federal confidentiality rules. (§42 CFR part 2). The federal rule prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by §42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at (§§2.12(c)(5) and 2.65.

This information shall be provided for the purpose of: ☐ Personal use by patient ☐ Sharing with other health care providers ☐ Other (please describe details) _____

For services provided on or after the following date ___/____/____ I would like my records: ☐ Printed (Patient Pickup) ☐ Mailed ☐ Faxed

This authorization will expire (insert a date or event): _____

If I fail to specify an expiration date or event, then this authorization will expire one year from the date signed below.

I understand that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notification to the person authorized to make the disclosure, identified above.
- My revocation will not be effective to the extent that the authorized person has relied on the authorization before receiving the revocation, but will be effective from that date forward.
- Failure to furnish this authorization will not affect my medical treatment/eligibility or enrollment for health coverage or the payment of health benefits.
- Once disclosed, the protected health information may no longer be protected by federal or state law and could be disclosed again by the recipient.

_____ _____/____/_____

*(Signature of Patient or Personal Representative**)* *(Date)*

** If a personal representative is signing the form on behalf of the individual whose medical information is to be disclosed, please print below the personal representative's name and describe his or her authority to act on behalf of the individual:

_____ _____

(Printed Name of Personal Representative) *(Authority of Personal Representative, Example: Parent of Patient, Child of Patient, Guardian of Patient)*

A fax or photocopy of this form shall be as effective as the original. A copy of this form shall be provided to the authorizing individual upon request.