LENZY DERMATOLOGY, PC

Phone: (413) 331-3676 Fax: (413) 331-4489

Authorization Form
For Release of Protected Health Information
TO LENZY DERMATOLOGY ASSOCIATES

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name:_____ **DOB**: _____

The health information you may release subject to this authorization is as follows:
_____ALL RECORDS_____ALL RECORDS EXCLUDING PRIVATE PAY RECORDS
_____ RECORDS FOR DATES:
_____

HIV/AIDS: I **DO** ___ **DO NOT** ___ consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** **Date:**

Release my protected health information FROM the following person(s)/entity:

Name:_____ **PHONE#:**_____

Street:_____ **FAX#:**_____

City:_____ **State:**_____ **Zip:**_____

TO: Lenzy Dermatology
1176 Memorial Drive * Chicopee, MA 01020

___ I give my permission for records to be faxed to Lenzy Dermatology at (413) 331-4489.

The reasons or purposes for this release of information are as follows:

_____

This authorization shall be in force and effective until the following event and/or date:

__ Expires after 30 days Expires one year after sign date Other: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Lenzy Dermatology.

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____

Signature of Patient or Personal Representative **Name of Patient or Personal Representative**

_____ _____

Date **Description of Personal Representative's Authority**