

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed by patient or patient's representative for all authorizations.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I hereby authorize _____

(name of physician, hospital or health care provider)

to release my personal health and medical information as described below to the following person(s) or health care provider(s).

DERMATOLOGY AND SKIN SURGERY
GINA HARNEY, M.D.
2760 VIRGINIA PARKWAY, SUITE 200
MCKINNEY, TEXAS 75071
469-587-7546
FAX 214-544-6737 OR 214-544-6739

Information to be disclosed:

- Complete health record(s)
- Progress notes
- Laboratory/radiology tests
- Hospital record(s)
- History and physical examination
- Consultation reports
- Other (please specify) _____

Covering the period(s) of health care from (date) _____ to (date) _____

I understand that this will include information relating to:

- a) Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- b) Behavioral health services/psychiatric care
- c) Diagnosis/treatment for alcohol and/or drug abuse

- ✓ I understand that this authorization is voluntary.
- ✓ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- ✓ I understand that I may inspect or receive a copy of the information described on this form if I ask for it.
- ✓ Unless otherwise cancelled, I understand that this authorization will expire one (1) year from this authorization.
- ✓ I understand that I may cancel this authorization at any time by notifying the providing health care provider in writing, but if I do, it won't have any effect on actions taken prior to receipt of the cancellation.
- ✓ I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the released information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from re-disclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Section B: This section must be completed only if a health plan or a health care provider has requested the authorization; the requesting party must complete this section.

1. The health plan or health care provider must complete the following:
 - a. What is the purpose of the use of disclosure? _____
 - b. Will the health plan or health care provider requesting the authorization receive financial compensation in exchange for using or disclosing the health information described above? (circle one)
 - YES
 - NO

Signature of patient/parent/guardian/patient representative

Date

REPRESENTATIVE

If signed by other than patient, indicate relationship: _____

Address of patient's representative: _____

Telephone number of patient's representative: _____

Printed name of patient's representative: _____

WITNESS NEEDED IF A REPRESENTATIVE SIGNS

Witness: _____

Signature

Date