Menlo Dermatology Medical Group
and Laser Center, Inc.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City, State, Zip Code _____

Home Phone Number _____ Work Phone Number _____

RELEASE OF INFORMATION TO:

Name/Organization: _____

Address: _____

City, State: _____ Zip Code: _____ Telephone #: _____ Fax #: _____

INFORMATION TO BE DISCLOSED COVERING THE FOLLOWING PERIOD(S): (Must be Specific)

Specify Dates of Treatment: _____ _____

_____ _____

PURPOSE OR NEED FOR THE DISCLOSURE IS:

- ☐ Continued Care
- ☐ Third Party/Insurance Review
- ☐ School Registration
- ☐ Legal Consultation
- ☐ Benefits Assignment
- ☐ Camp Registration
- ☐ Patient's Own Use
- ☐ Other: _____

INFORMATION TO BE RELEASED:

- ☐ Designated Record Set/Abstract
- ☐ Discharge/Clinical Summary
- ☐ Immunization Record
- ☐ Operative Procedure Report
- ☐ Consultation Report(s)
- ☐ History & Physical Report
- ☐ Laboratory Report
- ☐ Pathology Report
- ☐ Radiology Report
- ☐ Emergency Record
- ☐ Other: _____
- ☐ Entire Medical Record for Visit(s) specified above

EXPIRATION DATE:

_____

Specify Date, event, or condition upon which this consent will expire unless revoked at an earlier date/time.

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy Act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Mental Health Procedures Act, 1976 and the Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at anytime by written, dated communication to the recipient and/or that my consent expires under the circumstance above. I understand that once copies of my information are provided, the recipient cannot prevent re-disclosure.

I understand that any information disclosed in response to this request will not include information related to my treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse unless specifically checked below. An authorization for psychiatric care/treatment notes may not be combined with any other general release of information request.

☐ **AIDS/HIV Information** ☐ **Psychiatric Care/Treatment** ☐ **Treatment for Drug and Alcohol Use/Abuse**

Patient's Signature	Patient's Printed Name	Date of Authorization	☐ AM ☐ PM Time
Signature of Parent / Legal Guardian / Legal Representative	Printed Name of Parent / Legal Guardian / Legal Representative	Date of Authorization	☐ AM ☐ PM Time
Relationship to Patient			
Witnessed By	Witness Printed Name	Date	☐ AM ☐ PM Time