



Authorization for Use or Disclosure of Protected Health Information

Patient Name _____
Last First Middle Initial

Date of Birth: ____/____/____ SS#: ____ - ____ - ____ Medical Record #: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

I authorize Johns Creek Dermatology and Family Medicine to use or disclose my protected health information as indicated below to: _____
Name of entity to receive the information

Address City State Zip Code

I authorize: _____
Name of entity to receive the information
To release my protected health information to Johns Creek Dermatology and Family Medicine as indicated below.

Information to be released

Purpose of Disclosure

<input type="checkbox"/> From & to Date _____	<input type="checkbox"/> Changing Physicians
<input type="checkbox"/> History and physical Exam	<input type="checkbox"/> Continuing care
<input type="checkbox"/> Office Notes	<input type="checkbox"/> At patient request
<input type="checkbox"/> X-ray reports	<input type="checkbox"/> Second opinion
<input type="checkbox"/> Lab reports	<input type="checkbox"/> Legal
<input type="checkbox"/> Hospital records (Op note, Discharge info)	<input type="checkbox"/> Insurance/Workers' Compensation
<input type="checkbox"/> Medication records	<input type="checkbox"/> School
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

I understand that this authorization will expire: _____
Expiration Date or Defined Event

I understand that I may revoke this authorization at any time by notifying Johns Creek Dermatology and Family Medicine in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

Signature of Patient or Legal Guardian Date Effective Date