**Aberdeen Dermatology Associates**
**3 Lafayette St S**
**Aberdeen, SD 57401**
**605-226-0560**
**605-226-1653 *fax***

## PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patients Name: _____ Date of Birth: _____
Address: _____City/State/Zip: _____
Social Security Number (last 4 digits):_____Phone Number: _____
Maiden Name or other name used for records: _____

I hereby authorize Aberdeen Dermatology Associates to: (select one)

□ Release the records indicated below to □ Obtain the records indicated below from

Name/Facility: _____
Address: _____ City/State/Zip: _____
Phone: _____ Fax: _____

The following information from my medical records:
□ Standard Chart Copy
□ Complete Medical Record
□ Office Note(s)
□ Other _____
□ Pathology Report(s) Only
□ Lab Report(s) Only
□ Surgical Procedure(s)
Health Records between _____and_____dates.

This information to be disclosed for the purpose (s) of: □ Continued Healthcare □ Completion/Payment
□ Personal □ Other_____

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

If I fail to specify an expiration date, event, or condition, this authorization shall be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Aberdeen Dermatology Associates at the above address. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by those regulations.

_____ _____ _____
Signature of Patient or Patient's Representative Relationship to patient Date

Date Faxed/Mailed _____
Initials_____