Patient Authorization for Release of Protected Health Information

VISTA DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ Ph#: _____-_____-_____

I hereby authorize the physician / practice listed below to release my Protected Health Information (information contained in my medical records) to Vista Dermatology and affiliated healthcare providers.

_____ _____
Physician or Practice Name Phone

_____ _____
Address Fax

_____
City/State/Zip

Description of Information to be disclosed:

_____ Complete Medical Record
_____ Office Notes
_____ Operative Reports
_____ Laboratory Results
_____ Pathology Reports
_____ Radiology Reports

Covering the period from _____ to _____

Medical Records to be released to:

VISTA DERMATOLOGY
Attn: Medical Records
27511 IH-10 West, Building 2
Boerne, Texas 78006
Phone: (210) 698-0500
Fax: (210) 698-0600

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____Change of Doctor
_____ Other: _____

I understand the following:

1). I may revoke this authorization at any time by providing written notice to VISTA DERMATOLOGY.
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). VISTA DERMATOLOGY will not condition treatment or payment based upon my signing of this authorization and no longer protected by Federal Law.
4). The information disclosed by this authorization may be subject to re-disclosure by VISTA DERMATOLOGY.
5). I have reviewed this Authorization and understand its purpose and intent.
6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient / Guardian Signature Date Name (if other than Patient)