Mountain Pine DERMATOLOGY

Authorization for Release of Protected Health Information

_____

Patient's Name Date of Birth Telephone

_____

Address City State Zip

☐ To or ☐ From: **Mountain Pine Dermatology, PLLC**
1576 W Deer Crest St. Suite 100
Meridian, ID 83646
Phone: (208) 898-7467 Fax: (208) 314-0102

☐ To or ☐ From: ☐ Patient
☐ Other Name: _____
Address:_____
_____
Phone: _____ Fax:_____

☐ All Records
☐ Records related to: _____ Lab/X-ray/ Report(s)
☐ Records from dates _____ to _____

If you do not wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric, please initial here _____
Unless initialed here this information is deemed permissible to release.
This authorization is valid for 180 days

Notice to Patient:
When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy Officer at Mountain Pine Dermatology, PLLC. You do not have to sign this authorization and your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. Photocopies, facsimile or scan of this Authorization shall be considered to be the same as a signed original.

_____
Patient's Name (Printed)

_____
Patient or Personal Representative (Signature) Date