Russell Dermatology of Conway
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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____ SSN: _____

I acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment, and prognosis to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I am entitled to a copy of Russell Dermatology of Conway's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website www.russelldermatology.com or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim, Unless otherwise revoked, this authorization shall be in force and effect one year from today's date at which time this authorization expires.

I understand that to better care for my needs, records from previous providers may be requested. I authorize Russell Dermatology to obtain these medical records on my behalf.

FOR OFFICE USE ONLY

I authorize and request the following healthcare provider to release my medical records to Russell Dermatology:

_____

_____

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_____

Signature of Patient Date