

MELBOURNE DERMATOLOGY CENTER

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Dr. Adam H. Wiener, D.O.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Name and address of who is providing the information:

Name and address of who will receive the information: _____

Information being requested: _____

The information is being requested for the following reason:

- Treatment
- Other: (please explain) _____

- I understand by signing this form I authorize Melbourne Dermatology Center to either obtain or release the information I have requested to or from the above listed doctor or facility.
- I understand that in signing this form I authorize the disclosure of the protected health information described above. I understand that this authorization is voluntary. I understand that if the organization I authorize to receive the information is not a health plan or health care provider, federal or state law may no longer protect the released information and it will no longer be private.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on any actions they took before the received revocation I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it if I ask for a copy of the signed form.
- I understand I have the right to refuse authorization.
- This authorization will be in force until date: ___/___/___ or (event) _____ at which time expires. (Required-you must specify a date or event. Lifetime is not valid)
- I understand that the health information released may include information relating to sexually transmitted disease, acquired immune-deficiency syndrome (AIDS), or human immunodeficiency virus (HIV). The release may also include any information relating to behavioral or mental health services and treatment for alcohol and drug abuse.

Signature of patient or guardian

Date

Printed name of patient's representative: _____

Relationship to patient: _____