DERMATOLOGY ASSOCIATES OF MORRIS, P.A.
199 Baldwin Road
Parsippany, New Jersey 07054
973-335-2560 www.dermatologyassociatesofmorris.com

Patient Authorization for Practice to Release Protected Health Information

Dermatology Associates requires all patients to complete this form to indicate patient authorization to use and/or disclose certain protected health information (PHI) to the party or parties listed below in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law.

I authorize all Dermatology Associates of Morris staff to use or disclose to the following individual(s) until the specified expiration date(s):

Print Name(s) Phone Number(s) Relationship Expiration Date

_____

_____

_____

The listed individual(s) may receive all protected health information. If you would like to provide restrictions to this disclosure, please define those restrictions below:

_____

_____

_____

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Dermatology Associates has acted in reliance upon this authorization. My written revocation must be submitted to Tara Strauss, Privacy Officer, at 199 Baldwin Road, Parsippany, New Jersey 07054.

Print Patient Name: _____

Print Parent or Authorized Representative Name and State Relationship to Patient:_____

(If patient is under 18 or unable to sign)

Signature:_____

(Patient, Parent, or Authorized Representative)

Date:_____

Initials of Staff Witness: _____