# Westford Dermatology & Cosmetic Center

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## Patient Authorization for Release of Protected Health Medical Information

The patient will be given a copy of the completed authorization.

Name:________________________DOB:__________SS#:____________________

I, hereby, authorize Westford Dermatology and Cosmetic Center to:

- Disclose my protected health information to:
- Obtain my protected health information from:

Name: ______________________________________ Telephone:_________________________
Address:______________________________________ Fax:_____________________________

I understand that my health record may include general information related to my mental health, drug/alcohol abuse, sexually transmitted diseases, abortion, or other information I may consider sensitive. I understand that this authorization pertains to information obtained on or before the date this authorization was signed. I authorize the release of the following information for dates of service from______________________________through______________________________

Information to be disclosed:

- All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consult notes, inpatient, outpatient and emergency room treatment, all clinical charts, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages and records received by other medical providers
- Clinical photographs
- Lab, diagnostic testing and pathology reports
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs
- Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
  - Confidential HIV related information is any information indicating that a person had an HIV related test or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.
- Other________________________________________________

The purpose of the release of this information is for:

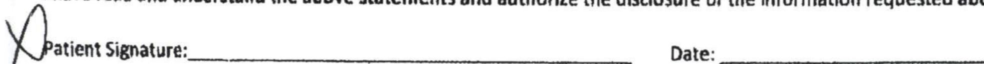
- Appointment with Specialist
- Transferring Care to a new provider
- Attorney/Legal Case
- Disability/Insurance Application or Claim
- Personal Use
- Pre-Employment
- Other (specify)____________________

I understand the following: This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical). Any disclosure carries the potential for unauthorized re-disclosure of this information. I release Westford Dermatology and Cosmetic Center from any legal liability that may arise from the disclosure or re-disclosure of this information. I have the right to revoke this authorization at any time by presenting a written request to Westford Dermatology and Cosmetic Center. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on:______________________________(Date)

If I fail to specify an expiration date, the authorization shall not be valid for more than 90 days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

I have read and understand the above statements and authorize the disclosure of the information requested above.



Patient Signature:______________________________________ Date: _______________________

Legal Representative or Legal Guardian:______________________ Date:_______________________

Witness:____________________________________________ Date:_______________________