

AUTHORIZATION FOR USE OR RELEASE OF YOUR HEALTH INFORMATION

**Attn: Privacy Officer
Dermatology Associates of Kentucky, PSC
250 Fountain Court
Lexington, KY 40509**

Patient Name (print): _____ **Date of Birth:** _____

Phone Number: _____

I authorize Dermatology Associates of Kentucky, PSC (DAK) to use or disclose my health information as described below.

Who: Person or organization receiving the information:

Name: _____

Fax: _____ Phone: _____

Address: _____

What: Specific description of information (including date[s] if appropriate):

Sensitive information: Please read carefully. By law you must sign below or we cannot release the following information:

- | | |
|------------------------------|-----------------------------|
| HIV/AIDS test/treatment | Sign here to release: _____ |
| Sexually transmitted disease | Sign here to release: _____ |
| Drug/alcohol problem | Sign here to release: _____ |
| Mental health information | Sign here to release: _____ |
| Genetic testing | Sign here to release: _____ |
| Sexual assault | Sign here to release: _____ |

Why: Specific description of the purpose of the use or disclosure:

I understand that this authorization is voluntary. If I do not sign this form, my healthcare from the Dermatology Associates of Kentucky and the payment for this healthcare will not be affected.

I understand that once my information is released, it may no longer be protected by federal privacy regulations.

I understand that I may see and copy the information described on this form if I ask for it, and I will get a copy of this form after I sign it.

I understand that this authorization will expire: _____

I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by notifying DAK's Privacy Officer in writing. But if I do, it won't have any effect on actions DAK took before the revocation was received.

Signature of patient or patient's representative **Date**

(Do not sign until the information above is filled in completely.)

Printed name if patient's representative: _____

Relationship to patient: _____

FOR INTERNAL USE—FILLING OUT FORM

A. If the patient is asking DAK to release the information, we must pre-fill several fields on the form and offer assistance in filling out the form.

Who—Instruct the patient to fill in the name of the person, department, or organization to receive the PHI, and their full mailing address.

What—Instruct the patient to fill in specific information about what information is to be released. For example, “all information related to my care when I was in the hospital in January, 2001.” Make sure the description is sufficiently clear to us to carry out the release.

Sensitive information—Remind the patient that we are not allowed to release this information without a signature on each relevant line.

Why—Fill out this field with “patient request” or instruct the patient to fill in “patient request.”

Expiration—Fill in “upon release of the specified information” or “30 days from signing.”

B. If DAK is seeking the patient’s permission for a use or disclosure (release), we must fill out Who, What, Why, and certain other information *before* asking the patient to read and sign the form.

Patient name—self-explanatory

Who—Fill in the name of the person, department, or organization to receive the PHI, and their address. (This may be a department head, such as Director of Marketing, or a third party.)

What—Fill in specific information about what PHI is to be released (used internally or disclosed to another party). For example, “all information related to the episode of care on January 10, 2001.” Make sure the description is clear. Make sure you follow the minimum necessary principle; don’t seek release of the whole record when a subset will do. While minimum necessary is not required by HIPAA for an Authorization, it is still good practice.

Sensitive information—Cross out any categories of sensitive information that are not being requested for release.

Why—Fill in the specific purpose for the use/disclosure. General purposes are not permitted if this organization is seeking the release. (If the patient is requesting the release/disclosure, either pre-fill this field with “patient request” or instruct the patient to fill in “patient request.” Do not require the individual to provide more information, other than to provide requested assistance in completing the “What” section of this form.)

Refusal to sign—If refusal to sign may affect payment, or if there may be other negative consequences of not signing, then you must attach a written explanation and a description of the consequences to the form.

Expiration—Fill in the date on which the authorization expires or the number of days from signing (e.g., “30 days from date of signing”) or an expiration event (e.g., “upon completion of research study”). Authorizations are not permitted to be open-ended except in limited, HIPAA-defined cases such as “for research repository.”