**AUTHORIZATION FOR USE OR RELEASE OF YOUR HEALTH INFORMATION**

**Attn: Privacy Officer**
**Dermatology Associates of Kentucky, PSC**
**250 Fountain Court**
**Lexington, KY 40509**
**Fax: 859-254-1814**

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

**Phone Number:** _____ **DAK Provider Name:** _____

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

❑ I am requesting records to be sent **TO** DAK ❒ I am requesting records to be sent **FROM** DAK

**Person or organization sending/receiving the information:**

Name: _____

Fax: _____ Phone: _____

Address: _____

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

_____

**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:** _____