AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS

_____ DOB:_____ SS#_____
Name of Patient

I understand that Western Dermatology Consultants, P.C. (WDC), from time-to time, may be requested to disclose my protected health information (PHI) with members of my family, a caregiver or a close friend. Therefore, I authorize the following individuals to access or receive my PHI:

Person's Name **Relationship to Patient**

_____

_____

_____

I authorize WDC to disclose my PHI for the following purposes:

- ☐ Make, change or cancel an appointment for me
- ☐ Obtain test or lab results on my behalf
- ☐ Discuss my current health condition or symptoms
- ☐ Pick-up written prescriptions or pharmaceutical samples on my behalf
- ☐ Other:_____

_____

I understand that a written authorization is required should any of the above named persons request copies of my medical records.

The following individuals are specifically NOT AUTHORIZED to access or receive any of my PHI:

Person's Name **Relationship to Patient**

_____

_____

_____

I understand that if information is requested via telephone, the caller may be asked to identify me by providing (a) my social security number and my date of birth as shown on WDC's records, and (b) the caller's full name shown above. If the request is made in person, the individual may be required to provide proper identification, including a picture ID.

I understand that in order to add or delete designated people from this list, I must notify WDC in writing. I also understand that I may revoke this authorization in its entirety by providing written notification to WDC, or signing a Revocation of Authorization for Disclosure of Health Information form provided by WDC.

_____ _____
Signature of Patient Date Signature of Personal Representative Date

_____ _____
Printed Name of Patient Printed Name of Personal Representative

_____
Personal Representative Relation to Patient