Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Blue Ridge Dermatology Associates, P.A. is authorized to release *Protected Health Information* (PHI) about the above named patient as indicated below. Your PHI includes general health information, laboratory tests and billing information. The purpose is to inform the patient or others in keeping with the patient's instructions.

How would you prefer that we communicate your PHI if you cannot be reached directly?

Please answer the following questions:

- Is it ok to leave detailed messages on your cell phone voice mail?
  ____ YES, please provide phone number: _____
  ____ NO
- Is it ok to leave detailed messages on your work voice mail?
  ____ YES, please provide phone number: _____
  ____ NO
- Is it ok to leave detailed messages on your home answering machine?
  ____ YES, please provide phone number: _____
  ____ NO

Is it ok to leave detailed messages with anyone other than yourself? If **YES**, please provide name(s) and phone number(s) of these individuals below:

_____ Print Name/Phone Number

_____ Print Name/Phone Number

_____ Print Name/Phone Number

_____ Print Name/Phone Number

I have reviewed and I understand this form. Please sign below.

Signature of Patient: _____, or

Signature of Legal Guardian: _____ (if patient is under 18 years of age)

Date: _____

Patient Information

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect for 1 year or until revoked by the patient

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