AUTHORIZATION FOR RELEASE OF INDIVIDUALLY-IDENTIFIABLE HEALTH INFORMATION

IMPORTANT: ALL SECTIONS MUST BE COMPLETED FOR THIS FORM TO BE VALID (Except where stated that a blank indicates "none.")

Your Name ______________________________ Your ID No. ______________

Your Address ______________________________ Your Phone Number ______________

I authorize the office of ____________________, my ____________________, to disclose to the person or entity listed below the following health information about me including, if applicable, information about HIV/AIDS, substance abuse treatment, and/or mental health services (Please be specific):

____

____

SPECIAL NOTE: If psychotherapy notes are to be used or disclosed, individual must initial here ________ and no other disclosure of health information may be authorized by this document.

Person or entity to receive information: ______________________________

Address, City, State and ZIP code ______________________________

Such disclosure shall be made under and subject to the following terms and conditions ("None" if left blank):

____

____

This authorization is valid until (specify a date or event related to the individual or the disclosure of the health information):

____

IMPORTANT NOTE TO THE INDIVIDUAL

It is completely your option whether to sign this authorization form. We cannot refuse to treat you if you choose not to sign this form. You may also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to request access to your identifiable health information, and how we may respond.

If you choose to sign this authorization form, you may revoke it later, except to the extent we have already acted in reliance on your authorization given on this form. If you wish to revoke this authorization, send a written or electronic note stating your request to revoke to our Privacy Official at the address, e-mail address, or fax number at right.

When your health information is disclosed as provided in this authorization, the recipient has no duty under the Health Insurance Portability and Accountability Act to protect its confidentiality. The recipient may re-disclose the information as he/she/it wishes, subject to applicable laws.

Provider Name: AMBER ROBBINS, M.D.
Address: 206 N. Brooks St.
Sheridan, WY 82801
Telephone: Phone: 307.672.8941
Fax: Fax: 307.672.7461
E-mail: www.robbinsdermatology.com

Provider may affix pre-printed information label here on each part of this form.

We will receive the following financial benefit from disclosing this health information about you ("None" if left blank): ______________

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

________________ ________________ ________________

Individual Signature | Name (Printed) | Date

If signing as the individual's personal representative, describe your relationship to the individual and the source of your authority to sign this form.

________________ ________________ ________________

Name (Printed) | Relationship to Individual | Source of Authority

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