Wasatch Dermatology

HIPAA Release of Information Authorization Form

Patient's Name:______________________________________ DOB: _______________________

I ____________________________________ hereby authorize Wasatch Dermatology to disclose my protected health information to:

Name:____________________Relationship:___________________Phone:_____________________

Name:____________________Relationship:___________________Phone:_____________________

Name:____________________Relationship:___________________Phone:_____________________

The information to be disclosed (check all that apply):

- ☐ Medical Records
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Bills/Claims Information
- ☐ Other ____

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I understand that:

I may revoke this authorization at any time in writing. Your notice will not apply to actions taken by the requesting person/entity prior to the date your written request is received by this office. You may revoke or terminate this authorization by submitting a written revocation to **Wasatch Dermatology, 5734 South 1475 East, Suite 300, South Ogden, UT 84403.**

If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

☐ Decline

This authorization expires on: ____________________________________

Signature of Patient/Legal Guardian: ____

Date: ___________________________