Wasatch Dermatology

(HIPAA)

Authorization to Use and Disclose Protected Health Information

Person for which authorization is given:

Patient's Name: ____Patient's DOB: ___________________

Names of authorized person(s):

(Check all that apply)

Name	DOB	Medical Records	Pathology	Lab	Other (Please specify)

Authorization shall remain in effect from dates_____________________ to_____________________.

I hereby authorize Wasatch Dermatology to use and disclose protected health information to the person(s) or entity (as listed above). I understand this authorization is voluntary and allows this/these person(s) to discuss the information specified Wasatch Dermatology, it's care providers and other personnel. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that the representatives of Wasatch Dermatology will make reasonable efforts to verify the identity of the person(s) requesting any PHI and may request proof of identity at the time of request. I understand that I must be provided with a copy of this form if I so request.

I understand that it is my responsibility to make any changes to this authorization and that all changes/ revocations must be submitted in writing to:

Wasatch Dermatology
ATTN: Medical Records
5734 S 1475 E STE 300
South Ogden, UT 84403

_____ DECLINE *(Check here if you do not want to release any information to family or friends)*

Date:__________________ Patient or Guardian Signature: ______________________________________

If Guardian, print name:_________________________________ Relationship: _____________________

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Wasatch Dermatology Rep Signature: _______________________________ Date: __________________

Print Name: ____________________________

Verified ID: Y / N
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