Authorization for Release of Information

Communication Release

Patient: Last Name: _____ First:_____ Date of Birth: _____/_____/_____

Commonwealth Dermatology is authorized to release protected health information about the above named patient in the following manner and to the identified persons named:

Permission to Leave Information:

☐ Voicemail: ph: (_____) _____-_____ ☐ Results of Lab tests/xrays/ biopsies ☐Other:_____

3rd Party: Who Can We Communicate With:

Name: _____ PH: _____ ☐ Financial ☐ Medical ☐ Can Pick up Items

Name: _____ PH: _____ ☐ Financial ☐ Medical ☐ Can Pick up Items

Name: _____ PH: _____ ☐ Financial ☐ Medical ☐ Can Pick up Items

Text/Email Communication:

For text or email communication to occur accept the disclosure below:

☐ **For email and or Text Communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication if selected.

Text Communication: PH: (_____) _____-_____ ☐Appointment Reminder

Email Communication: _____ ☐Appointment Reminder

Photos:

☐Photos of patient received by patient or legal guardian: We can receive and upload photos of patient that you send to us into the patient's medical record.

☐Photo taken by staff: We may want to photodocument a spot or rash as a part of the patient's medical record.

Patient Rights:

- **I have the right to revoke this authorization at any time.**
- **I may inspect or copy the protected health information to be disclosed as described in this document.**
- **Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.**
- **Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.**
- **I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.**

This authorization will remain in effect until revoked by the patient.

_____Date _____ Signature

of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)