LOW COUNTRY
DERMATOLOGY
AND AESTHETICS

Authorization for Use/ Release of Health Information

This form applies only to the release and disclosure of your health information.
It is not a consent for treatment and is not intended for any other purposes.

By signing this form, I authorize Low Country Dermatology, LLC to use, release or disclose the protected health information described below to:

_____
(Name of Person and/or Organization to whom information should be sent)

_____

_____

_____
(Address of Person/Organization to whom information should be sent)

(Please send this information on or about): _____/_____/_____
MONTH DAY YEAR

NOTE: Information will not be resent without another signed authorization.

This authorization expires upon fulfillment of request or on: _____/_____/_____

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.):

_____

I authorize the following information to be sent to the address above:

- ☐ Copies of all medical records for the period _____/_____/_____ TO _____/_____/_____
- ☐ Copies of the information described below from _____/_____/_____ TO _____/_____/_____
- ☐ History & Physical Examination
- ☐ Lab, X-ray Reports
- ☐ Reports from Other Physicians
- ☐ Other (Please Specify): _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions. I understand that there may be information in these records that I would not want released.

The following information should ***not*** be released, even if occurring during dates above -

_____

_____

_____

Please describe any special requirements such as faxing, certified mail, extended expiration date, certification, and the like -

_____

_____

_____ Patient Initial _____

I have been provided a copy of Low Country Dermatology, LLC Notice of Privacy Practices and am aware of the charges for copies of records made pursuant to this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with Low Country Dermatology, LLC Privacy Officer or other appropriate office personnel.

I understand that Low Country Dermatology, LLC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Low Country Dermatology, LLC from all legal liability that may arise from this authorization.

Signature _____ Date _____/_____/_____

Name _____ SSN # _____ – _____ – _____ DOB _____/_____/_____

If the signature above is not that of the patient, I am acting for the patient because _____

Signature _____ Relationship to Patient _____

The patient or their representative may revoke this authorization by notifying in writing Low Country Dermatology, LLC designated Privacy Officer. Federal Law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential that the protected health information released under this authorization may be subject to re-disclosure by the recipient. Any such re-disclosure is beyond the control of Low Country Dermatology, LLC.