THE DERMATOLOGY INSTITUTE OF BOSTON

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Information

Name:_____ **Date of Birth:**_____

The Dermatology Institute of Boston, PC is authorized to release protected health information about the above named patient to the person(s) listed below and in the methods selected.

Individual(s) to Receive Information: (e.g.- spouse or family members)
*list anyone that you approve to receive information

Check Information Allowed:

	Financial	Medical
1._____ Phone #:_____	_____	_____
2._____ Phone #:_____	_____	_____
3._____ Phone #:_____	_____	_____

Appointment Reminders: please select the type you would like to receive from our office

Email Messages ☐ Telephone/Voicemail ☐ Text Message ☐

At my request the following items may also be released: please select all that apply

☐ Entire Record ☐ Financial Record ☐ Office Visit Notes ☐ Biopsy Reports
☐ Operative Reports ☐ Allergies ☐ Consultation Reports ☐ Lab Reports

Email Communication:

I understand that if email correspondence is not sent in an encrypted manner there is a risk that it could be accessed inappropriately. I still elect to receive email communication. **Initial**: _____

Email Address:_____

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 disclosure 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.
I understand that released information may include a communicable disease diagnosis such as HIV.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

_____ _____
Signature of Patient or Patient Representative Date

_____
Description of Patient Representative's Authority* (if applicable) ***PLEASE ATTACH NECESSARY DOCUMENTATION**