TOWN CENTER DERMATOLOGY

16759 Main St., Suite 201
Wildwood, MO 63040

AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIED HEALTH INFORMATION

Patient name: _____**Date of birth:**_____ **Record Number**:_____

I, or my personal representative, hereby authorize Town Center Dermatology to use or disclose protected health information regarding my care and treatment. I understand that:

1. Information relating to **ALCOHOL/DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, **GENETIC TESTING**, and/or **CONFIDENTIAL HIV-RELATED INFORMATION** will not be disclosed unless I specifically authorize such disclosure by placing my initials in the appropriate space(s) in Item 8(b).

2. Information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV-related information, the recipient is prohibited from re-disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who may receive or use my HIV-related information without authorization.

3. I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed below, except to the extent Town Center Dermatology has already relied upon this authorization.

4. Signing this authorization is voluntary. Town Center Dermatology may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

5. Provider releasing this information: **Town Center Dermatology (Christopher Kling MD)**
16759 Main Street, Suite 201, Wildwood, MO 63040

6. Purpose for release of information: □ At my request □ Continuity of Care □ Other: _____

7. Person(s) receiving this information: (identification required for pick-up)
□ Send to Name: _____
Address : _____
Fax #: _____
□ I will pick it up □ My personal representative _____ will pick it up.

8. Description of information being released:
(a) Specific date(s) of service (required; list all dates):_____
I would like (choose one)**:**
□ My entire Medical Record □ An abstract (pertinent information related to the above listed date(s))
□ Lab reports – (specify: pathology or blood work) _____

(b) Include information relating to (initial beside each applicable category):
□ **Alcohol/Drug Treatment** ____ □ **Mental Health Treatment** ____ □ **Genetic Testing Information** ____
□ **HIV-related Information** ____(If yes, complete an official release form)

9. Date or event on which this authorization will end:

□ One-Time Request □ Specific Event or Date: _____

10. Signature: By signing below I acknowledge that I have read and agree with all of the above.

Signature:_____ **Date**: _____/_____/_____

Print name of patient or personal representative: _____
□Parent □ Guardian □Health Care Agent □ Administrator/Executor □ Other: _____

THE PATIENT OR PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM UPON SIGNING