HIPAA Authorization Form

I,_____, hereby authorize the use or disclosure of my protected health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

REN Dermatology is authorized to disclose the following protected health information to _____.

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

- _____
  OR
- All past, present, and future periods of health care information may be shared.

3. VALIDITY OF AUTHORIZATION FORM

This Authorization form is valid beginning on_____ and expires on_____.

4. ACKNOWLEDGEMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature: _____ Date:_____