Integrated Dermatology of Groton L.L.C
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HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. arts 160 and 164**

I authorize____________________________________(healthcare provider) to use and disclose the protected health information describe below to

Name____Address____

Phone # _______________

This authorization for release of information will expire on _____________________.

I Authorize the release of my individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, etc.).

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This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative Relationship to Patient

____

Printed Name of Patient **Date of Birth** **Date**

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Current Address and Phone Number

____

If Moving Please List New Address and Phone Number

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