

1911 North Webb Road
Wichita, KS 67206
(316) 682-7546 Fax (316) 682-7554

PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient (Please Print) _____
Date of Birth

Street Address City State Zip _____
Phone Number

Maiden Name or other name used for records

I here by authorize: (Please Print) To release to: (Please Print)

- The following information from my medical records
- Complete Health Records
 - Health Records between dates _____
 - Other (Please specify) _____

Covering the period from _____ to _____.

This information is be disclosed for the purpose (s) of: _____

Specify the date, extent or condition upon which this authorization expires _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Moeller Dermatology at the above address. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in sixty days from the date below.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by those regulations.

Moeller Dermatology is not responsible for completeness, legibility, or omittance caused by the copying of any medical records from another institution.

Signature of Patient or Patient's representative _____
Date

Relationship to patient

Date Faxed/Mailed _____
Initials _____