Derrow Dermatology

Amy E. Witt, M.D. & Laurie Fashakin, PA-C 800 N. Maitland Avenue, Suite #202, Maitland, FL 32751 (407) 389-2020

Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name	Date of Birth
Address (street, city, state, zip code)	Telephone Number

The following individual or organization is authorized to **make the disclosure**:

○ Derrow Dermatology Associates LLC ○ Other (Please Specify): _____

This information may be **disclosed to and used by** the following individual or organization:

○ Derrow Dermatology Associates LLC ○ Other (Please Specify): _____

The following information is to be disclosed:

Yes	No		Yes	No	
○	○	Biopsy/Pathology Report(s)	○	○	Surgical Notes (dates: _____)
○	○	Clinic Notes (dates: _____)	○	○	Other (please specify below:)

_____

_____

Sensitive Information: I understand that the information in my record may include information such as sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

a. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.
b. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition (or if I do not specify an expiration date, event or condition, this authorization will expire in one year)

_____ _____

Signature of patient or legal representative Date

_____ _____

If signed by legal representative, what is relationship to patient Date