

**STANDARD AUTHORIZATION
OF USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**



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INFORMATION TO BE USED OR DISCLOSED

The information covered by this authorization includes:

TO:

PERSONS AUTHORIZED TO USE OR DISCLOSE INFORMATION

Information listed above will be used or disclosed by:

Name of person or organization

FROM:

PERSONS TO WHOM INFORMATION MAY BE DISCLOSED

Information described above may be disclosed to:

Name of person or organization

EXPIRATION DATE OF AUTHORIZATION

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to Sunnycoast Dermatology. You should contact the office to terminate this authorization.

POTENTIAL FOR RE-DISCLOSURE

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

PRINT Name of Patient

SIGNATURE of Patient

DATE

SIGNATURE of Patient Representative

DATE