FARADY
Dermatology Associates

Authorization Form for Release of Protected Health Information from Farady Dermatology Associates

2700 W Anderson Ln #403 Austin, TX 78757 (P)512-786-3498 (F)512-243-7236
1500 W. 34th Street Austin, TX 78703 (P)512-485-7700 (F)512-485-7702

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: _____ DOB: _____

The health information you may release subject to this authorization is as follows:

_____ ALL RECORDS _____RECORDS FOR DATES: _____

HIV/AIDS: I DO__ DO NOT__ consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial: _____ Date: _____**

Release my protected health information to the following person(s)/entity:

Name:_____

Street:_____

City:_____ State:_____ Zip:_____

The reasons or purposes for this release of information are as follows:

_____

This authorization shall be in force and effective until the following event and/or date:

___Expires after 30 days ___Expires after one year after sign date Other:_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Farady Dermatology Associates.

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____

Signature of Patient or Personal Representative **Name of Patient or Personal Representative**

_____ _____

Date **Description of Personal Representative's Authority**