CAPITAL DISTRICT DERMATOLOGY ASSOCIATES, P.C.

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450 Route 9W
Glenmont, NY 12077
Phone: (518) 434-8121 * Fax: (518) 426-0620

Protected Health Information Release Authorization

I _____ hereby authorize _____
Patients full name Medical Facility or Physicians name

To disclose my health information under the terms described below. Pursuant to this authorization, my health information may be disclosed to, and used by the following individual or organization.

Name and Address of Physician or Organization you are authorizing your health information to be disclosed to:
Capital District Dermatology Associates Fax #: 518-426-0620 Phone#: 518-434-8121
450 ROUTE 9W
Glenmont, NY 12077

Specific information to be used: _____

Dates of service: _____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING AT THE BOTTOM

I understand that if my records contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) related information; such information will be released pursuant to this authorization. Confidential HIV related information is any information indicating that an HIV test was done; HIV virus is present; HIV related illness or AIDS; or any information, which could indicate that a person has been potentially exposed to HIV. I also understand that if my records contain information concerning Drug, alcohol abuse and or treatment, or behavioral mental health services or Psychiatric treatment, domestic/sexual abuse, such information will be released pursuant to this authorization, unless otherwise revoked; this authorization will expire in 90 days.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical facility. I understand that the revocation will not apply to any information that has already been released in response to this authorization. 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 revoked I understand that this authorization will expire in 90 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to insure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries the potential of an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the medical facility.

Exceptions to the above: (circle all that apply)	Mental health	Substance abuse	HIV/AIDS	Domestic/sexual abuse
Name:	DOB:		SS#:	
Address:	State:	Zipcode:	Phone #:	
Sign:		Date:		
Relationship:	Self	Parent/Guardian		