beacon skin & surgeries DERMATOLOGY

- 110 South Blvd. Suite 100, Rochester Hills, MI 48307 Ph 248-852-1900 Fax 248-852-1919
- 37595 W. Seven Mile Rd. Suite 240, Livonia, MI 48152 Ph 734-307-2400 Fax 248-852-1919
- 46591 Romeo Plank Rd Suite 205A, Macomb, MI 48044 Ph 586-368-3600 Fax 248-852-1919
- 44000 W 12 Mile Rd Suite 103, Novi, MI 48377 Ph 248-946-4787 Fax 248-716-5956
- 8338 Allen Rd, Suite 201, Allen Park, MI 48101 Ph 313-346-9900 Fax 248-852-1919

Authorization to Disclose Protected Health Information

Patient Name:_____Maiden Name: _____ Date of Birth:_____

Address:_____ Phone: _____

AUTHORIZATION: I authorize **Beacon Skin & Surgeries,** locations listed above, to use and disclose the above-named individual's protected health information to and be used by the following person or organization:

☐ Myself: Choose how you want to receive the records:

☐ mailed to my address listed above ☐ to be picked up in the office ☐ sent to my Patient Portal

☐ Other (send to another person/organization as listed below):

_____ _____

Name of person/organization authorized to receive the protected health information Relationship to patient (ie mother, son)

_____ _____ _____

Address Phone Number Fax Number

I authorize the release of the following information which may contain records relating to demographic information; alcohol and drug abuse/treatment; genetic information; psychological or social work counseling; infections or communicable diseases including sexually transmitted diseases, HIV or AIDS, tuberculosis or hepatitis.

☐ My Complete Medical Record

or Components of the Medical Record noted below

☐ All Beacon Skin & Surgeries Clinical Notes (Office visits, Procedure notes, Communication notes)

☐ All Pathology reports (ie Biopsy Results)

☐ All Other Lab tests and Radiology Reports

☐ Other (specify i.e. a particular record/date range): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that if I give permission, I have the right to change my mind and revoke this authorization at any time. This must be in writing to the Privacy Officer as set forth in the Notice of Privacy Practices. I also understand that any uses or disclosures already made with my permission cannot be taken back. If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that the above person/organization who would have received the information may have the right to contest health care coverage claims.

Unless otherwise revoked, this authorization will expire on _____. If not specified, authorization will expire five (5) years from date of signature below.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

By signing this authorization, I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules. I further understand that I may request a copy of this signed authorization.

Patient Signature: _____**Date:** _____

Alternative Consent Authority and Signature
Patient's Parent or Guardian: _____Relation: _____
Patient's Parent or Guardian Signature: _____Date: _____