

Cutaneous Pathology PA, and Pathologists Diagnostic Laboratory, PA

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize:

**Cutaneous Pathology PA and
Pathologists' Diagnostic Lab, PA
3195 Maplewood Drive Suite 102
Winston-Salem, NC 27103**

to disclose personal health information to:

Name: _____
Address: _____

Phone Number: _____
Fax: Number: _____

This authorization permits the use and/or disclosure of the following individually identifiable health information about me:

- Name
- Insurance
- Lab Report
- History & Physical
- Address
- Social Security Number
- Test Results
- Consultation
- Phone Number
- Entire Medical Record
- Radiology Report & Images

This release includes drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:

The information is limited to the following treatment dates:

Purpose of disclosure:

Authorization will expire:

This information may be shared:

- In Person
- Pick Up
- Fax
- Mail
- Other (Describe) _____

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that the practice has already acted in reliance upon this authorization. My written revocation must be submitted to:

**Cutaneous Pathology PA & Pathologists Diagnostic Lab, PA
3195 Maplewood Drive, Suite 102
Winston-Salem, NC 27103
Phone: 1-877-416-0501 (toll free)
Fax: 336-760-1398**

Signed by:

Signature of Patient or Legal Guardian Relationship to Patient

Print Patient's Name Patient's Date of Birth

Print Name of Legal Guardian, if applicable Date signed