To Cutaneous Pathology PA

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize:
Cutaneous Pathology PA
1900 S Hawthorne Rd, Ste 366
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
1900 S Hawthorne Rd, Ste 366
Winston-Salem, NC 27103
Phone: 1-888-760-1388 (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