

Lake Loveland Dermatology, P.C.
776 W Eisenhower Blvd
Loveland, CO 80537
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Authorization Form for Release of Protected Health Information

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

Patient Name: _____ **DOB:** _____

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

Name: _____ **PHONE #:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Fax #: _____

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

_____*ALL RECORDS* _____*RECORDS FOR DATES:*

_____*ALL RECORDS FOR THE FOLLOWING CONDITION:*

HIV/AIDS: I **DO** _____ **DO NOT** _____ consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

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

Name: _____ **PHONE #:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

I give my permission for records to be faxed to # _____

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

This authorization shall be in force and effective until the following event

_____**Expires after 30 days** _____ **Expires 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 Lake Loveland Dermatology, P.C.

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 re-disclosure by the recipient and may no longer be protected by federal HIPAA 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

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority