FLORIDA SKIN CANCER AND DERMATOLOGY SPECIALISTS, P.A.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Florida Skin Cancer and Dermatology Specialists, P.A. to use and/or disclose certain protected health information (PHI) about me to

_____.
Name of entity to receive this information

This authorization permits Florida Skin Cancer and Dermatology Specialists, P.A. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____

_____.

The information will be used or disclosed for the following purpose:

_____.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Florida Skin Cancer and Dermatology Specialists, P.A. 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 acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

P.O. Box 357730
Address

Gainesville	**FL**	**32635-7730**
City	*State*	*Zip Code*

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name — Date

_____ _____
Print Name of Patient or Legal Guardian — Patient's Date of Birth

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION