Authorization for Release of Information

Patient Name: _____ **Date of Birth:** _____

Blue Ridge Dermatology Associates, P.A. is authorized to release *Protected Health Information* (PHI) about the above named patient as indicated below. Your PHI includes general health information, laboratory tests and billing information. The purpose is to inform the patient or others in keeping with the patient's instructions.

How would you prefer that we communicate your PHI if you cannot be reached directly?

Please answer the following questions:

- Is it ok to send detailed messages via the portal?
  ____ **YES**, please provide email address: _____
  ____ **NO**
- Is it ok to leave detailed messages on your cell phone voice mail?
  ____ **YES**, please provide phone number: _____
  ____ **NO**
- Is it ok to leave detailed messages on your work voice mail?
  ____ **YES**, please provide phone number: _____
  ____ **NO**
- Is it ok to leave detailed messages on your home answering machine?
  ____ **YES,** please provide phone number: _____
  ____ **NO**

Is it ok to leave detailed messages with anyone other than yourself? If **YES**, please provide name(s) and phone number(s) of these individuals below:

_____ Print Name/Phone Number

_____ Print Name/Phone Number

_____

_____

I have reviewed and I understand this form. Please sign below.

Signature of Patient: _____, or

Signature of Legal Guardian: _____ (if patient is under 18 years of age)

Date: _____

Patient Information

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect for 1 year or until revoked by the patient

Issued: 9/1/11
Revised: 8/27/2021