Dermatology & Laser Institute of Colorado, P.C.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name		Date of Request	_____/_____/_____
Patient DOB	_____/_____/_____	Social Security Number	

By signing this authorization, I authorize Dermatology and Laser Institute of Colorado, P.C. to use and / or disclose certain protected health information (PHI) about me to:

_____

Practice / Business Name

_____

Practice / Business Address

This authorization permits Dermatology and Laser Institute of Colorado, P.C. to use and / or disclose the following individually identifiable health information about me. All records of service and dates of service will be supplied unless otherwise specified. Please check box(es) that apply:

- ☐ **All medical information contained in chart**
- ☐ **Lab Work (only)**
- ☐ **Pathology Results (only)**
- ☐ **Last Visit (only)**
- ☐ **Photos (only)**
- ☐ **Other** _____

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

_____.

If requested by the patient, purpose may be listed as "at the request of the individual." 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 one year after the signature date at the bottom.

I do not have to sign this authorization in order to receive treatment from Dermatology and Laser Institute of Colorado, P.C. I understand that 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 re-disclosure 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:

DERMATOLOGY & LASER INSTITUTE OF COLORADO, P.C.
9695 S YOSEMITE ST, STE 175
LONE TREE CO 80124
ATTN: PRIVACY OFFICER
FAX: 720-344-0296

_____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Print Name of Patient or Legal Guardian | Date