Center for Advanced Aesthetics

Authorization/Revocation for Release of PHI

In accordance with HIPAA, a patient's health record is private and considered "Protected Health Information" ("PHI"). PHI includes, but is not limited to, general medical information, biopsy results, blood/lab/other test results, treatment information, and other potentially sensitive or personal information.

Check One:

☐ Add PHI Authorization ☐ Revoke PHI Authorization ☐ Both Add & Revoke

Patient Information:

Patient's Last Name ______ Patient's First Name ______ Middle Initial ______

Mailing Address (inc. Apt. #) ______ City ______ State ______ Zip ______

Date of Birth (DOB) ______ Phone Number ______

Patient hereby AUTHORIZES[1] the release of PHI to the individual(s)/entity(ies) listed below:

Full Name ______ Relationship ______ Phone Number ______

Full Name ______ Relationship ______ Phone Number ______

Patient hereby REVOKES any PHI authorizations to the individual(s)/entity(ies) listed below:

Full Name ______ Relationship ______ Phone Number ______

Full Name ______ Relationship ______ Phone Number ______

TO BE READ AND SIGNED BY PATIENT OR LEGAL REPRESENTATIVE:

By completing and signing this form, patient, or patient's legal representative, agrees and acknowledges:

1. This authorization and/or revocation is given freely and under no pressure from any individual(s) to do so.
2. Patient understands his/her privacy rights and the purpose and use of this form.
3. A new authorization and/or revocation may be submitted at any time.

Patient/Representative Signature ______ **Date** ______

Print Name ______ **Witness Signature** ______

[1] This authorization is valid until revoked in writing. Please be advised that an authorized PHI recipient may disclose your PHI to unintended parties. Shah Dermatology, LLC is not responsible for any such unauthorization disclosures, and federal or state privacy laws may no longer protect your PHI in such situations.

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