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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_______________________________________ DOB:______________________

Today's Date:____________________________ ID#____________________________________
(for office use only)

I authorize the following individual or organization to release my protected health information:

____Physician/office

____Address

____Phone/Fax

The following information may be released(MUST BE
SPECIFIC:____

____

____

This information may be released to:

_______________________________________Name

_______________________________________Address

_______________________________________Phone/fax

This information is being requested for the following purpose(s):

____

____

This authorization will expire on ___/___/___ (DD/MM/YR); or as described below:

____

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PLEASE SEE OTHER SIDE

I hereby authorize the release of my protected health information as described and understand and acknowledge the following:

- I may refuse to sign this authorization, however, I do understand that my records will not released if I do not sign it.
- My treatment or billing for treatment by Swinyer-Woseth Dermatology will not be affected by my decision to sign or not sign this authorization.
- If the organization or person authorized to receive this information is not required to comply with federal privacy regulations (such as an employer or a school), the released information could be re-disclosed by them and would no longer be protected.
- I may inspect or copy the protected health information requested in this authorization as permitted by federal privacy regulations.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to the Swinyer-Woseth records custodian. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
- If I have any questions about this authorization, I may contact the records custodian at 801-266-8841, who will provide me with more information about this authorization or about our privacy practices.

I certify that I have read, signed and received a copy of this authorization.

____

Patient Name (Please print)

____ ______________________

Signature of Patient (or Patient's representative) Date

____

Relationship of Patient representative to Patient