SCHOLES DERMATOLOGY

AUTHORIZATION TO ACCESS, USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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

Address: _____

To: Scholes Dermatology, LLC

526 Shoup Ave W Suite A

Twin Falls ID, 83301

Phone # 208-734-5555

Fax # 208-734-4790

From: _____

Provider: _____

Phone # _____

Fax # _____

Purpose for Disclosure: Insurance Legal Personal Continued Care/Treatment Workers Comp Other

Information being disclosed:

Chart notes Biopsy Reports Pathology Results Lab results Allergy Test/Treatment

Other: _____

Date of service(s): _____

I understand that I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. ***To revoke this authorization, I must submit a written revocation to Scholes Dermatology.***

I understand that my health care cannot be conditioned on this authorization unless the purpose is solely to obtain and disclose information for a third party such as an employer.

I understand that information disclosed by Scholes dermatology pursuant to this authorization be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

Signature: _____ **Date:** _____

Relationship to the Patient : _____

This Authorization will expire in 6 months from date signed