STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

Carolina Skin Surgery Center

Information to be Used or Disclosed

Complete Health Records
Photographs
Pathology reports
Other:____
____
____

Purpose of the Disclosure:____

Method that information is being released: ☐ **Mail** ☐ **Email** ☐ **Fax**

Please send to: ____
____
____

Will this information be used for marketing? Yes____ No____

Persons Authorized to Use or Disclose the Above Information: ______________________
(Name of person or organization)

Persons to Whom Information May Be Disclosed to:______________________
(Name of person or organization)

Expiration Date of Authorization

This authorization is effective through (check one)☐ _____/_____/_____ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

____
Name of patient (Type/Print) and/or Representative

____
Signature of Patient or Representative Date

Carolina Skin Surgery Center
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