5346 STADIUM TRACE PARKWAY Suite 100
Hoover, AL 35244-4583

Authorization for Use and Disclosure of Protected Health Information

I authorize release of my medical/health information to the Receiving Facility as indicated below:

TO (Receiving Facility)	From (Releasing Facility)
Facility Name: ______________________	Facility Name: ______________________
Attention: ______________________	Attention: ______________________
Address: ______________________	Address: ______________________
City: ______________________	City: ______________________
State & Zip: ______________________	State & Zip: ______________________
Phone and Fax #s: ______________________	Phone and Fax #s: ______________________

Please release the following medical/health information:

Patient Name: ______________________ DOB: ______________

Patient Address: ____

City: ______________ State: ______________ Zip: ______________

Date (s) of Service to be released: ______________________ Medical Record #: ______________

Social Security Number: ______________________ Telephone # ______________

Identification of Patient or Personal Representative:

The patient must present proof of identification by providing one of the following:

____ Driver's License ____ Social Security Number ____ two utility bills
____ Work Photo Badge ____ Other Photo Identification ____ Notarized Signature
____ Other ____

If you are signing as the personal representative of the patient, you may be asked to submit proof of your authority to act as a personal representative by the Releasing Facility. If Pure Dermatology & Aesthetics is the Releasing Facility and if the patient is deceased, a copy of the death certificate and/or proof of executor/administrator must be present before medical/health information is released.

Please provide the purpose of this release of your medical/health information:

____ At request of Patient/Personal Representative ____ Legal ____ Insurance
____ Other, please specify: ____

(Continue on next page)

Information to be released:

____ Discharge summary	____ Emergency Room Record	____ Face Sheet
____ History and Physical	____ Laboratory Reports	____ Operative Reports
____ Pathology Reports	____ Entire Medical Record	____ Radiology (X-rays)**
____ HIV/AIDS	____ Emergency Requested Info	____ UB/Acct'g Info

If the patient is deceased a copy of the death certificate and/or proof of executor/administrator must be present before protected health information is released.

I understand that if the person or entity that receives my protected health information is not a health care provider, healthcare clearinghouse or health plan covered by federal privacy regulations that the information used or disclosed according to this authorization may be redisclosed by the recipient and may be no longer protected by applicable federal or state privacy laws.

I understand that all **x-ray films must be returned within 30 days of issuance.

I understand that PDA is allowed by state and federal law to charge a reasonable fee for the photocopying of the requested protected health information.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment.

I understand that I may revoke this authorization in writing at any time by submitting my revocation to the PDA Director of Health information Management except to the extent that PDA has taken action in reliance on the authorization. The authorization will expire within 90 days if no expiration date or event is defined.

I understand that PDA will release the protected health information described herein unless otherwise prohibited.

I understand that if I am requesting protected health information for an incapacitated patient, my signature certifies that the patient is indeed incapacitated i.e. unable to appear in person for authorization of release of protected health information.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or Human Immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that if the materials disclosed contain data related to alcohol and/or drug abuse, the information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits making any further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by such regulations.

I hereby release PDA from any liability related to PDA release of this information to the persons or entities described herein.

Signature of the patient: ______________________________

Signature of personal representative: ______________________________

Authority of personal representative: ______________________________

Signature of Witness: ______________________________

Date of Authorization: ____________________ Expiration Date/Event: ____________________

(This authorization will expire in 90 days unless otherwise specified.)
Copy provided to patient or personal representative)

NOTARIZED SIGNATURE IS REQUIRED FOR ALL EXTERNAL REQUESTS