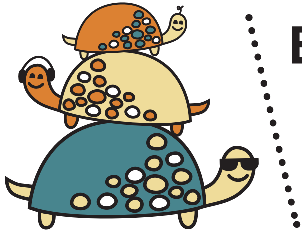

Burkhart Pediatric & Adolescent Dermatology

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Cary, NC 27518
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HIPAA Authorization to Use and Disclose Protected Health Information

Instructions: Burkhart Pediatric & Adolescent Dermatology, PLLC is HIPAA compliant. We take seriously our legal obligation to protect confidential patient information. We give all patients and their families the opportunity to read our HIPAA Notice of Privacy Practices (NPP) and ask for their written acknowledgment. Please help us maintain our respect for patient privacy and comply with the law by completing this authorization form, giving us permission to discuss patient information with specific individuals such as spouses, other adults, children, etc.

I have had the opportunity to read Burkhart Pediatric & Adolescent Dermatology, PLLC's HIPAA Notice of Privacy Practices regarding the Use and Disclosure of Protected Health Information (PHI). I understand that I may refuse to sign this authorization to release PHI and that my refusal to sign will in no way affect my treatment, payment, enrollment in a health plan, or eligibility for benefits. I also understand that my signature is required in order to complete this request.

Burkhart Pediatric & Adolescent Dermatology, PLLC may use and disclose either all of my PHI or specific components of my PHI as specified below only for the specific purpose identified below and for the time period specified below or until the completion of the event for which I have provided the authorization. My authorization is not a blanket permission to use and disclose PHI.

At all times, I retain the right to revoke this authorization to use and disclose PHI. Should I wish to exercise this right, I will submit a written request to the Burkhart Pediatric & Adolescent Dermatology, PLLC Practice Manager.

I understand that the party that receives my PHI may re-use or re-disclose the information received. At that point, the PHI may no longer be protected under federal or state confidentiality rules.

I understand that Burkhart Pediatric & Adolescent Dermatology, PLLC may charge a fee for copying the medical records for which I have provided authorization for use and disclosure.

I have read the information related to use and disclosure and understand that I may request a copy of this form if desired.

Continued

Burkhart Pediatric & Adolescent Dermatology

Authorization to Use and Disclose Protected Health Information - page 2

Medical Record Number: (to be filled in by practice) ____________________

Patient Name: ____ Date of Birth:________________

Address: ____

Home Phone: (_____) _________________________ Cell: (_____) ____________________________

Work: (_____) _______________________________

As the patient or the individual authorized to act on behalf of the patient, I authorize the use and disclosure of the following protected health information (PHI) relating to me as described below.

I, (NAME): ____, hereby authorize Burkhart Pediatric & Adolescent Dermatology, PLLC to release the following information:

◯ Entire Chart

◯ Office Notes

◯ Procedure Notes

◯ Radiology Report(s)

◯ Lab test results

◯ Mental Health

◯ Other: ____

Release Information to:

Name: ____ Relationship: ____________________

Name: ____ Relationship: ____________________

Purpose for Release:____

Time Period: (e.g. calendar year; upcoming hospitalization, etc.)__________________________________

Signature of Patient or of Individual Authorized to Act on Patient's Behalf:

____

Printed name: ____ Relationship to patient: _______________

Date: _____________