RAPPAPORT DERMATOLOGY
I Paul Rappaport, M.D.
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME:_____DOB:_____
ADDRESS:_____
CITY:_____ZIP:_____
PHONE NUMBER:_____

I, _____, authorize the use or disclosure of information from my medical records to:
TO:_____
ADDRESS:_____
PHONE:_____FAX:_____

___Complete Health Record ___Pathology/Lab Results ___All Records from _____to_____
___Itemized billing records or specific dates from ____to_____
___Other_____

Purpose or Need for Disclosure:
___Continued Patient Care ___Personal Use ___Attorney/Legal ___Insurance Claim
___Disability Determination ___Other_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of patient is prohibited.

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in twelve months.

Please mail or fax all authorizations to release medical records to: RAPPAPORT DERMATOLOGY. If faxing, please include a cover sheet with a statement of confidentiality. To 518-587-6836.

A copy of the signed original record release may serve as the original release. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions above disclosure of my health information I can contact Rappaport Dermatology at 518-587-9243.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient(If Legal Representative) Witness