



MICHELE M. THOMPSON, M.D.
D E R M A T O L O G Y

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____

Phone Number: _____

RELEASE RECORDS FROM:

DOCTOR/ CLINIC: _____

ADDRESS: _____

PHONE: _____

FAX: _____

TO BE SENT TO:

DOCTOR/ CLINIC: _____

ADDRESS: _____

PHONE: _____

FAX: _____

Information to be disclosed (check all that apply):

- Entire medical record
- Most recent Clinic Note, Date: _____
- Clinical Notes, last 2 years
- Pathology Reports, last 2 years
- Laboratory Tests, last 2 years
- Other _____

Please do **not** send health information related to (check all that apply):

- HIV (AIDS virus)
- Drug/Alcohol Abuse
- Sexually Transmitted Disease (STD)
- Mental Health

Reason for disclosure:

- Transfer of Care
- Second Opinion/Consult
- Other _____
- Release to Another Physician
- Legal/Attorney Review
- Insurance Claim
- Personal Use

I authorize the use or disclosure of my health information as described above for the purpose listed. I understand that I have the right to withdraw permission for the release of my information at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed. Unless revoked in writing sooner, this authorization will expire 180 days from the date of signature below. I understand that this authorization is voluntary and I may refuse to sign this authorization without affecting my health care or the payment for my health care.

Signature of Patient or Legal Representative

Date

Print Name (if other than patient)

Relationship to Patient

Revised: 03/2020