dermcare PHYSICIANS & SURGEONS

Patient Authorization for Release of Protected Health Medical Information

Name: _____ DOB: _____ SS#: _____

I, hereby, authorize (Dermcare Physicians and Surgeons (Formerly Northeast Surgery Center) to

☐ Disclose my protected health information to:
☐ Obtain my protected health information from:

Name: _____ Telephone: _____

Address: _____

I understand that my health record may include general information related to my mental health, drug/alcohol abuse, sexually transmitted diseases, abortion, or other information I may consider sensitive. I understand that this authorization pertains to information obtained on or before the date this authorization was signed. I authorize the release of the following information for dates of service from _____through _____.

Information to be disclosed:

Send records to:
Dermcare Physicians and Surgeons
22 Mill Street, Suite 304
Arlington, MA 02476
P: (781) 641-4900, Fax: (781) 641-4904

☐ Physician's Office notes, history and physical and consultation report
☐ Clinical Photographs
☐ Reports of diagnostic testing and laboratory testing
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
Confidential HIV related information is any information indicating that a person had an HIV related test or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by indicating and signing this form.
☐ Behavioral health services/psychiatric care
☐ Treatment for alcohol and/or drug abuse
☐ Other: (please specify) _____

The purpose of the release of this information is for:
☐ Appointment w/Specialist ☐ Transferring Care to a new provider ☐ Attorney/Legal Case
☐ Disability/Insurance Application/Claim ☐ Personal Use ☐ Pre-employment ☐ Other (specify) _____

I understand that: This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical). I may inspect or copy information to be disclosed as provided in the Notice of Information Practices. There may be a fee for photocopying my health information. Any disclosure carries the potential for unauthorized re-disclosure of this information. I release Dermcare Physicians and Surgeons from any legal liability that may arise from the disclosure or re-disclosure of this information. I have the right to revoke this authorization at any time by presenting a written request to: **Medical Records Dept, Dermcare Physicians and Surgeons, 27 Village Square, Chelmsford, MA 01824,** Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on: (Date) _____
If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

I have read and understand the above statements and authorize the disclosure of the information requested above.

Signed:

Patient Signature	Date
* Legal Representative	Date
Witness	Date

- **If signing as a legal representative, also provide appropriate paperwork to support representative status.**
- **A copy of completed authorization must be given to the patient**

Form date: 08/08/17