TURNER
DERMATOLOGY

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH (HIPAA)

I authorize my physician and/or administrative and clinical staff of Haverford Dermatology, LLC to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below; protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and Relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend).

Name of Person or Entity:_____

Phone #:_____Relationship:_____

Name of Person or Entity:_____

Phone #: _____ Relationship:_____

_____

Please sign **ALL** marked **(X)** Signature lines listed below. **DATE:**_____

I can request a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment, and health care operations.

X_____Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand that I, the patient, or the patient's representative, am/is responsible for payment of all charges for services rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

X_____Signature of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to my insurance carrier(s).

X_____Signature of the Patient or Patient Representative

If signed by Patient Representative, please list name of representative_____

Please inform the receptionist if you would like a copy of the Notice of Privacy Practices.