Authorization for Release of Protected Health Information (PHI)

_____

PATIENT NAME DATE OF BIRTH PHONE NUMBER

☐ To or ☐ From: **Mountain Pine Dermatology, PLLC**
4664 N Penngrove Way Suite 100
Meridian, ID 83646
Phone: (208) 898-7467 Fax: (208) 398-2120

☐ To or ☐ From: ☐ Patient
☐ Other: Provider Name: _____
Clinic/Company Name: _____
Address:_____
_____
Phone: _____ Fax:_____

☐ All Records
☐ Records related to: _____ Lab/X-ray/ Report(s) Other: _____
☐ Records from dates _____ to _____

☐ Pick-up Records
☐ Fax Records to Patient: #_____
☐ Mail Records to:

_____

ADDRESS CITY STATE ZIP

If you do not wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric, **please initial here _____**
Unless initialed here this information is deemed permissible to release.
This authorization is valid for 180 days

Notice to Patient:
When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy Officer at Mountain Pine Dermatology, PLLC. You do not have to sign this authorization and your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. Photocopies, facsimile or scan of this Authorization shall be considered to be the same as a signed original.

_____

SIGNATURE of Patient or Personal Representative* DATE

*Personal Representative includes: parent of any minor patient under 18 years of age, legal guardian, power of attorney etc.

Mountain Pine DERMATOLOGY

Release of Medical Information (ROI) to Another Family Member or Individual

PATIENT NAME | DATE OF BIRTH | PHONE NUMBER

If you wish to have Mountain Pine Dermatology, PLLC release your medical or billing information to another individual or family member you must sign this form. Signing this form will only give information to individuals indicated below.

To request records from another medical clinic, please fill out a separate Release of Protected Health Information (PHI) form.

1. NAME: _____
   PHONE: _____
   RELATION TO PATIENT: _____

2. NAME: _____
   PHONE: _____
   RELATION TO PATIENT: _____

3. NAME: _____
   PHONE: _____
   RELATION TO PATIENT: _____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

SIGNATURE of Patient or Personal Representative* | DATE

*Personal Representative includes: parent of any minor patient under 18 years of age, legal guardian, power of attorney etc.