Andrus & Associates Dermatology, P.A.
Compound Authorization for Release of Information

I have received a copy of the *Notice of Privacy Practices* for the above named practice.

I authorize release of medical information to my primary care or referring physician, to consultants, if needed, and as necessary to process insurance claims, insurance applications and prescriptions.

Name of Patient _____ Date of Birth _____

_____

Signature Date

Andrus & Associates is authorized to release protected health information pertaining to the above named patient to the entities below:

Entity to Receive Information	**Description of information to be released** ***Check*** each that can be given to person/entity on the left in the same section
Your Answering Machine/Voice Mail/US Mail	☐ Appointment reminders ☐ Results of pathology/other labs ☐ Financial, including family billing information
Spouse Parent(provide name)_____ Parent(provide name)_____	☐ All information ☐ Medical information, including results of tests ☐ Financial, including family billing information
Other(provide name)_____ Phone #s_____ Other(provide name)_____ Phone #s _____	☐ All information ☐ Medical information, including results of tests ☐ Financial, including family billing information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification.
I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to Andrus & Associates' Privacy Officer.
I understand that my treatment will not be conditioned on signing this authorization.
I understand that I have the right to refuse to sign this authorization.

_____ Date_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)