

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE  
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

\_\_\_\_\_  
**PATIENT'S NAME**

\_\_\_\_\_  
**DATE OF BIRTH**

By signing this authorization, I authorize Dermatique (Dermedx Dermatology P.C.) to use and or disclose my Protected Health Information (PHI) to or for the party or parties listed below.

This authorization permits Dermatique (Dermedx Dermatology P.C. ) to disclose PHI to: *example; parent, other relatives, siblings, school, etc.* (Please write full names and relationship. Please write the full name of the school district.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization further permits Dermatique (Dermedx Dermatology P.C.) to disclose PHI to the following health professionals. (Please write the full name and address).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*The practice (Circle One) can / cannot treat my unaccompanied child (if over 16 but not of majority). \*\*\*\*\*

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke or change this authorization in writing except to the extent that Dermatique (Dermedx Dermatology P.C.) has acted in reliance upon authorization. My written revocation, or changes must be submitted to the Privacy Officer.

Signed by: \_\_\_\_\_

Signature of Patient  
Or Legal Guardian

Relationship to Patient

\_\_\_\_\_  
Print Name of Patient  
Or Legal Guardian

\_\_\_\_\_  
Date

# Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been given the opportunity to receive a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the waiting room area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

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SIGNED

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DATE

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Print Name

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Telephone

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Patient's Name (s):

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Relationship to Patient: