Amherst, Ma 01002
Telephone: (413) 549-7400 * Fax: (413) 549-7402

AUTHORIZATION FOR RELEASE OR TO OBTAIN INFORMATION

Patient Name: ____ Date of Birth: _________________

Check One: ( ) Pick Up ( ) Mail ( ) Fax ( ) Secure Email

I hereby authorize Pioneer Valley Dermatology, PC to ( ) obtain from or ( ) disclose to my protected health information:

____
Name and address

The specific information to be disclosed is:
[ ] Entire [ ] Laboratory Reports [ ] Pathology

[ ] Other (Specify): __________________________ Purpose: ( ) Medical ( ) Legal ( ) Personal ( ) Other: _____________

RELEASE OF HIV/AIDS AND/OR GENETIC INFORMATION (required for each release)

HIV/AIDS
[ ] I hereby authorize release of protected health information pertaining to HIV testing and/or diagnosis and/or treatment of Acquired Immune Deficiency Syndrome (AIDS) solely to the person or organization described above and solely for the purpose stated above.

GENETICS
[ ] I hereby authorize release of protected health information pertaining to genetic test results to the person or organization described above and solely for the purpose stated above.

____ __________________________
Signature of Patient or Patient's Representative Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that information used or disclosed as a result of this Authorization may be further used or disclosed by someone who obtains such information and therefore may no longer be protected by Federal Privacy laws. Except to the extent allowed by law, Pioneer Valley Dermatology, PC will not condition treatment on my signing this Authorization. I acknowledge that I have signed this Authorization *voluntarily*. I also understand that I have the right to revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it. To revoke this Authorization, please notify us in writing and mail it to our Pioneer Valley Dermatology, PC office.

If this authorization is for a parent/guardian to access their child's record, the access to view their child's medical record (paper or electronic) is limited to 30 days from date of this Authorization and to the records noted in this Authorization.

This Authorization expires on: _____________________ (or if unspecified, one year from the date of signature).

____ ______________________________
Signature of Patient or Patient's Representative Date

If Patient Representative, describe Representative's authority or relationship to the Patient: _____________________________

I understand that my alcohol and drug treatment records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my Alcohol and Drug Abuse Records cannot be re-disclosed without my express authorization.

WE WILL PROVIDE YOU A COPY OF THIS SIGNED FORM Rev 08/2015 (BD)

PLEASE ALLOW 7-14 BUSINESS DAYS FROM WHEN WE RECEIVE THIS SIGNED FORM FOR MEDICAL RECORD PROCESSING.