RADIANT
DERMATOLOGY & AESTHETICS

HIPAA Privacy Authorization Form

This form is used for authorization for use or disclosure of PHI, protected health information.
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name:_____
Patient Date of Birth: _____

I _____ (name) authorize Radiant Dermatology and Aesthetics permission to all my health care and medical service providers and payers to disclose and release my protected health information described below to:

Name(s):	Relationship:	Phone Number:
_____		
_____		
_____		

Health Information to be disclosed (Check all that apply):

- ☐ My information is not to be released to anyone.
- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information: (check as appropriate):
  - ☐ Mental Health Records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other, please specify:
    _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- ☐ All past, present, and future periods, OR
- ☐ Date:_____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers in writing.)

_____ _____
Signature of Patient or Patient Representative Date