COLUMBIA SKIN CLINIC

Authorization for the Use and Disclosure of Protected Health Information

Patient's Name: _____ DOB: _____ SSN: _____

I hereby authorize Columbia Skin Clinic to use or disclose my protected health information (PHI) as described below. I understand that the information I authorize a person or facility to receive may be re-disclosed and no longer be protected by state and federal regulations. I understand there is no charge for the first copy of my medical record and that any additional request to copy will incur a $30 administration fee.

Information to be used/disclosed – please check those that apply:

□ History & Physical	□ Consultation Reports	□ Operative Reports
□ Progress Notes	□ Operative Reports	□ Entire Medical Record
□ Billing Summary	□ Labs	□ Other: _____

Type of delivery:

□ Mail Records □ Patient Pickup □ Fax: _____

Entity Providing Information (Name and Address):	Entity Receiving Information (Name and Address):

Purpose of Disclosure – please check those that apply:

□ Patient Request	□ Treatment or Consultation
□ Payment	□ Billing or Claims
□ Transfer	□ Other: _____

Right of the Patient:

I understand that I have the right to withdraw this authorization, except to the extent that Columbia Skin Clinic has already acted on the authorization, by sending a written notice addressed to Columbia Skin Clinic, 3600 Forest Drive, Suite 400 Columbia, SC 29204.

I understand that the information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____	_____	_____
Patient's Signature or Legally Qualified Representative	Patient/Guardian Print Name	Date