



**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:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Operative Reports     |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Operative Reports    | <input type="checkbox"/> Entire Medical Record |
| <input type="checkbox"/> Billing Summary    | <input type="checkbox"/> Labs                 | <input type="checkbox"/> 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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Patient Request | <input type="checkbox"/> Treatment or Consultation |
| <input type="checkbox"/> Payment         | <input type="checkbox"/> Billing or Claims         |
| <input type="checkbox"/> Transfer        | <input type="checkbox"/> 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, 3 Richland Medical Park Drive Suite 500, Columbia, SC 29203.

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