

PATIENT AUTHORIZATION FOR INFORMATION RELEASE

By signing this authorization, I authorize Pioneer Valley Dermatology to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

Description of authorized information: (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)

The described information may be released to:

This authorization will expire on _____.
{Expiration Date or Defined Event}

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 this authorization in writing except to the extent that Pioneer Valley Dermatology has acted in reliance upon this authorization. My written revocation must be submitted to Pioneer Valley Dermatology's Privacy Officer at 29-B Cottage Street, Amherst, MA 01002.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name Date

Print Name of Patient or Legal Guardian