Haddonfield Dermatology ASSOCIATES

HIPAA PRIVACY AUTHORIZATION FORM

1. **AUTHORIZATION:**

I authorize *Haddonfield Dermatology Associates* to use and disclose the Protected Health Information (PHI) from my visit with your office to the following (individual or group the patient wishes to share PHI with- *this can be an individual or another doctor, or both):*

_____ **OR**

☐ I do not authorize the release of my PHI to any other person or group unless necessary for billing purposes.

☐ I authorize my Health Insurance Company or third party payer to pay my insurance benefits directly to *Haddonfield Dermatology Associates.*

2. **EFFECTIVE PERIOD:**

This authorization is valid for one year for release of medical information covering the period of healthcare from:

Today's Date: _____ **to December 31, 20**____

3. **CONTACT INFORMATION:**

CHOOSE ONE OPTION REGARDING MEDICAL INFORMATION:

May we speak with anyone other than yourself regarding your medical condition?

☐ Yes
☐ No

If yes: name and relationship of person you authorized _____

*Can we leave detailed messages regarding your medical condition or prescriptions on voicemail? If so, what is the best phone number?

_____

CHOOSE ONE OPTION REGARDING BILLING INFORMATION:

May we speak with anyone other than yourself regarding your billing information?

☐ Yes
☐ No

If yes: name and relationship of person you authorized_____

*Can we leave detailed messages regarding your billing on voicemail? If so, what is the best phone number? _____

- ***This authorization shall be in force and in effect until the last day of this year at which time it will expire and a new one will have to be filled out on the first visit of the next year.***
- ***I understand that I have the right to revoke this authorization, in writing, at any time.***
- ***I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.***
- ***I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.***
- ***I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.***
- ***This medical information may be used by the person I authorize to receive this information for the purpose of medical treatment or consultation, billing or claims payment, or other purposes as I may direct.***

SIGNATURE of patient or patient's representative: _____

PRINTED name of patient or patient's representative: _____