RICKS ADVANCED DERMATOLOGY & SKIN SURGERY

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

This authorization permits Ricks Advanced Dermatology & Skin Surgery to disclose/obtain your health information, including information about medical treatment, substance abuse treatment, mental health treatment and HIV/AIDS status. Please review it carefully.

Patient name: _____ DOB: _____

Address: _____ City/State/Zip: _____

SS #: _____ Phone: _____

I authorize the below: to disclose my health information to:

Ricks Advanced Dermatology & Skin Surgery _____

5120 SW 28th Street _____

Topeka, Ks. 66614 F #: (785) 730-8700 _____

for the following designated purpose: ____ treatment ____ payment

Other (state purpose): _____

Records to be disclosed :

____ all records ____ nursing notes

____ operative ____ billing

____ lab ____ other _____

The approximate dates of service to be obtained are: _____

I understand that this authorization will expire one year from the date of my signature or upon the following event:

_____

I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be disclosed and no longer protected by those regulations.

I also understand that certain records may be protected by federal or state law, including alcohol/drug treatment or communicable diseases, and I am requesting that any and all such protected records be released under this authorization.

I also understand that I may revoke this authorization at any time by delivering a written revocation to the Administrative Offices of Ricks Advanced Dermatology & Skin Surgery, 5120 SW 28th Street, Topeka, Ks. 66614.

If I revoke this authorization, it will have no effect on actions already taken in reliance on this form.

I understand the Ricks Advanced Dermatology & Skin Surgery will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I authorize Ricks Advanced Dermatology & Skin Surgery to obtain/disclose the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit Ricks Advanced Dermatology and Skin Surgery to obtain/disclose the records/information upon presentation of a photocopy of this authorization.

Patient / Personal Representative Signature _____

Relationship of Personal Representative to patient _____ Date _____