DERMATOLOGY ASSOCIATES OF LANCASTER, LTD.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please select ONLY 1 option below:

☐ I **do not** authorize disclosure other than to myself.

☐ I authorize Dermatology Associates of Lancaster, Ltd. to disclose medical information pertaining to my treatment and/or care to the following:

Name *(please print)*	Relationship	( ) Phone Number
Name *(please print)*	Relationship	( ) Phone Number
Name *(please print)*	Relationship	( ) Phone Number

This form shall expire one (1) year from the date of signature, unless a different expiration date or term is expressly selected below:

☐ Initials_____This authorization expires on this specific date: _____

☐ Initials_____This authorization expires when minor patient reaches the age of 18 years.

May we leave test results on your voicemail? Yes ☐ No ☐

Please complete below:

Patient Name *(please print)* Date of Birth

Signature Date

Relationship: ☐ Patient ☐ Parent ☐ Legal Guardian/POA

FOR INTERNAL OFFICE USE ONLY

Patient hereby revokes above authorization: •

Signature Date