ROBERT B. HOPP, M.D. & ASSOCIATES

CENTER FOR EXCELLENCE IN DERMATOLOGY™ PLLC

Authorization to Disclose Protected Health Information (PHI)

_____ _____

Patient Name Date of Birth

_____

Phone Number

I request and authorize the Center for Excellence in Dermatology to disclose the protected health information (PHI) of the above named patient to the following individual(s):

Name: Relationship: Phone Number:

_____ ☐ Spouse _____

☐ Other:_____

Name: Relationship: Phone Number:

_____ ☐ Spouse _____

☐ Other:_____

Name: Relationship: Phone Number:

_____ ☐ Spouse _____

☐ Other:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer/Compliance department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 3 years from the date signed below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Policy Officer/Compliance Officer.

_____ _____

Signature of patient or legal representative Date