

SOUTH VALLEY DERMATOLOGY

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DISEASES
OF THE SKIN,
HAIR & NAILS

MEDICAL AND FINANCIAL INFORMATION AUTHORIZATION RELEASE

In general, the Health Information Portability and Accountability Act (HIPAA) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. We will release information **ONLY** by the means you authorize on this form. We will take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. We will keep a record of all PHI disclosures. Uses and disclosures may be permitted without prior consent in an emergency.

I authorize the staff of South Valley Dermatology to release any **financial** information to the following people:

Name of Spouse: _____
 Name of Partner: _____
 Name of Parent or Guardian: _____
 Other: _____

I authorize the staff of South Valley Dermatology to release any **medical** information to the following people:

Name of Spouse: _____
 Name of Partner: _____
 Name of Parent or Guardian: _____
 Other: _____

Please complete requested information and check all that apply:

Telephone Communication

Written Communication

<input type="checkbox"/> Home Telephone #:		<input type="checkbox"/> OK to mail to my home address
<input type="checkbox"/> OK to leave detailed message on home answering machine/voice mail	<input type="checkbox"/>	OK to mail to my work/office address (please list):
Cell phone #:	<input type="checkbox"/>	OK to fax to the following #:
<input type="checkbox"/> OK to leave detailed message on cell phone voice mail	<input type="checkbox"/>	OK to mail promotional material: <input type="checkbox"/> To my home <input type="checkbox"/> To my work/office
<input type="checkbox"/> OK to leave message with call back number only: <input type="checkbox"/> On home answering machine/voice mail <input type="checkbox"/> On cell phone voice mail	<input type="checkbox"/>	OK to mail information regarding Research Studies: <input type="checkbox"/> To my home <input type="checkbox"/> To my work/office
Daytime telephone #:	<input type="checkbox"/>	Other: List any restrictions:
<input type="checkbox"/> OK to leave detailed message on daytime telephone answering machine/voice mail		
<input type="checkbox"/> OK to leave message with call back number only on daytime telephone answering machine/voice mail		

I have received the Notice of Privacy Practices of South Valley Dermatology and I have been provided an opportunity to review it. I understand I may revoke any part of this authorization at any time by giving written notice to the Privacy/Security Officer at South Valley Dermatology Center.

Patient Signature _____ Date _____