VALLEY DERMATOLOGY ASSOCIATES, INC., PS & ESTHETICS 3911 Castlevale Road, Suite 301 Yakima, WA 98902 509-966-7899

**Authorization to Disclose Protected Health Information (PHI)**

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Patient Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number

**I request and authorize Valley Dermatology Associates to disclose the protected health information (PHI) of the above named patient for 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 it in writing and present my written revocation to the Privacy Office/Compliance Department. I understand that 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 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 disclosure 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 Office/Compliance Officer.

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Signature of patient/legal representative Date

PHI/CV/0715