Release of Medical/Billing Information Authorization Form

Patient Name: ____ Date of Birth: ___J ___J ____ _

CHOOSE ONE:

☐ I authorize Advanced Skin & Laser Center to release my medical and billing information to the individuals listed below.

☐ I DO NOT authorize Advanced Skin & Laser Center to release my medical records and billing information to anyone other than myself.

NAME OF DESIGNATED PERSON	RELATIONSHIP	PHONE
Please Print		
Please Print		
Please Print		

The HIPAA privacy rule permits health care providers to communicate with patients regarding their health care, including protected health information (PHI) and billing information. This includes communication with the patient through mail, phone, fax or some other manner.

I understand that Advanced Skin & Laser Center is permitted by the HIPAA privacy rule to leave information regarding my appointment, including the date and time, on any phone number provided. Advanced Skin & Laser Center may request a return phone call to our office when speaking to any individual that answers the phone. If I only want confidential communication between Advanced Skin & Laser Center and myself, I must provide written notice to Advanced Skin & Laser Center on a form provided upon my request.

I understand that it is my responsibility to keep Advanced Skin & Laser Center informed of any changes to this information and that I may revoke this authorization at any time by written notice to Advanced Skin & Laser Center on a form provided upon my request.

Signature of Patient or Parent/ Guardian　　　　　　Date

Print Name of Patient or Parent/ Guardian　　　　　　Relationship to Patient

Revised 09/24/2019