Authorization to Disclose Protected Health Information

I authorize or decline Frontier Dermatology, including its physicians, medical assistants, and staff, to discuss my Protected Health Information (PHI)—including appointment details, care plans, and billing matters—with the following family members or friends involved in my medical care:

☐ **I do not authorize** the release of my medical information to anyone other than myself.
OR
☐ **I authorize** the release of my medical information to the following individual(s):
(Please provide details below.)

Name: _____

Home Phone: _____ Mobile Phone: _____

Relationship to Patient: _____

Name: _____

Home Phone: _____ Mobile Phone: _____

Relationship to Patient: _____

Name: _____

Home Phone: _____ Mobile Phone: _____

Relationship to Patient: _____

This authorization shall remain in effect for all past, present, and future periods unless revoked by a written notification.

I understand I have the right to revoke this authorization, in writing, at any time, Except where we have already made disclosures in reliance on your prior consent.

I understand information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes of office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Patient Name **Patient Date of Birth**

_____ _____

Patient Signature (or Legal Guardian) **Date**