Precision Dermatology and Skin Surgery, P.A.

Board Certified in Dermatology

Fellowship Trained in Dermatologic Surgery

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OTHERS

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966 (HIPAA), in order for your physician or the staff of Precision Dermatology and Skin Surgery, P.A. to discuss your condition with members of your family or other individuals that you designate other than your Primary Care Doctor, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **authorize** Precision Dermatology and Skin Surgery, P.A. to verbally release any or all information concerning my medical care. To the following individuals:

Name (Print): _____ Relationship: _____ Phone: (_____) _____

Name (Print): _____ Relationship: _____ Phone: (_____) _____

_____ I **do not authorize** Precision Dermatology and Skin Surgery, P.A. to verbally release any or all information concerning my medical care.

Patient Signature: _____ Date: _____

Print Name: _____

Relationship to patient (if other than patient): _____