GOLDEN RULE
— skin clinic, p.c. —

Authorization for Release of Protected Health Information (PHI)

Information regarding patient for whom authorization is made:

Patient Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: Golden Rule Skin Clinic
Address: 704 Eastside Blvd. Hastings, NE 68901
Phone: 402-460-1090
Fax: 402-460-1091

Information regarding person or entity who can receive and use this information:

Name: _____

Address: _____

City: _____ State_____ Zip: _____

Phone: _____ Fax: _____

Dates of service requested: _____
Description of Information to be released: (check all that apply)

___ Progress Notes ___ Laboratory Reports
___ Biopsy Results ___ Surgical Reports
___ Consultations ___ Two-way verbal exchange of communication
___ Other: _____
I understand that the information in my health record m ay include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV, behavioral or mental health, alcohol/drug abuse or any such related information

Description of the purpose of the use and/or disclosure: (check one)

__ Continuing Care __ Second Opinion __ Social Security/Disability
__ Collaboration of Care __ Emergency/Acute Care __ Insurance
__ Confidential Legal Purpose __ Personal Use __ Other_____

I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure ty the recipient and may no longer be protected by federal and state privacy regulations. Golden Rule Skin Clinic may charge a fee for this service. This authorization will expire by law 180 days from the date of this authorization unless otherwise specified. This authorization will be in effect until _____ (day or time specified)

I also understand that I may revoke this authorization at any time by notifying Golden Rule Skin Clinic. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated. The revocation will not affect my actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date