Andrus & Associates Dermatology, P.A.
Compound Authorization for Release of Information

I have the received a copy of the ***Notice of Privacy Practices*** for the above named practice.

I authorize release of medical information to my primary care provider, referring physician, or consultants, as needed for treatment, payment, and healthcare operations, and as necessary to process insurance claims and prescriptions. A separate authorization may be required to disclosure to third party entities, e.g. life insurance underwriter.

Print Name of Patient:_____ Date of Birth:_____

Signature of Patient:_____ Date of Authorization:_____

Andrus & Associates is authorized to release protected health information pertaining to the above named patient to the entities below:

Entity to Receive Information	**Description of Information to be Released** Please ***check*** each item that can be released to the person/entity on the left in the same section.
You: ☐ Answering machine/voicemail ☐ US Mail ☐ Email	☐ Appointment Reminders ☐ Results of pathology/lab test ☐ Financial and billing information
Family: ☐ Name of Spouse:_____ Phone Number: _____ ☐ Name of Parent(s): _____ Phone Number: _____ ☐ Name of Child(ren):_____ Phone Number:_____	☐ **All Information**(appointments, billing, test results, etc.) ☐ Appointment Reminders ☐ Medical information, including results of pathology and lab tests ☐ Financial and billing information
Other: ☐ Name:_____ Phone Number:_____	☐ **All Information**(appointments, billing, test results, etc.) ☐ Appointment Reminders ☐ Medical information, including results of pathology and lab tests ☐ Financial and billing information

Rights of the Patient:

- I understand that this authorization will expire two years from the date of signature or upon an expiration event, such as a minor reaching the age of majority.
- I understand that I have the right to revoke this authorization at any time by sending a written notification before the expiration date or event.
- I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to Andrus & Associates Dermatology, P.A.'s Privacy Officer.
- I understand that my treatment will not be conditioned on signing this authorization.
- I understand that I have the right to refuse to sign this authorization.

_____//_____

Signature of Patient or Personal Representative Date

_____//_____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority*

*Attach necessary documentation.

Reason for non-signature on back →