

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize Summit Dermatology to use and/or disclose certain protected health information (PHI) about me to or for the party(s) listed below.

This authorization permits Summit Dermatology, P.C. to use or disclose the following individually identifiable health information:

- Office Notes
- Pathology Report
- Lab Results
- Entire Chart

To the following party(s)

Name _____

Street Address _____

City, State, Zip _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Summit Dermatology, P.C. has acted in reliance upon this authorization. My written revocation must be submitted to Summit Dermatology's Privacy Officer at 8890 N. Union Blvd., Suite 207, Colorado Springs, CO 80920.

Signed by _____

Signature of Patient or Legal Guardian _____

Date signed _____

Patient's Name _____

Patient's Date of Birth _____

Print Name of Patient or Legal Guardian _____

Relationship to Patient _____