Patient Authorization for Richard M. Greene, M.D., P.C. to Receive

Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and Richard M. Greene, M.D., P.C. may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Richard M. Greene, M.D., P.C. provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Patient Name:_____ Date of Birth_____

Check specific purpose of disclosure:

O Transfer of care O Single use authorization O Continuance of care O Insurance O Other_____

Indicate specific records to be released:

Office visit date(s) _____ and/or specific diagnosis _____

Check type of information to be released:

O Progress/office notes O Pathology reports O Laboratory reports O Other_____

Individuals who may receive the information:

GREENE DERMATOLOGY	**2150A South Clinton Avenue**
Richard M. Greene, M.D., P.C.	2140B South Clinton Avenue
Dermatology and Dermatologic Surgery	Rochester, NY 14618
PHONE: 585-256-0555	FAX: 585-256-0583

Individuals who may release the information: _____

_____

(Please include Provider/Person/Facility, address, phone number and fax number)

Authorization valid for: O This request only.

O One year from the date of this authorization or _____ (insert date). This authorization applies to the records of the treatment on or prior to the date of this authorization.

O This request and for medical records of any **future** treatment of the above until: _____ (insert date).

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to Richard M. Greene, M.D., P.C.

By signing this form, you authorize Richard M. Greene, M.D., P.C. to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the practice administrator.

This authorization was signed by: _____

Printed Name – Patient or Representative

Signature: _____ **Date:** _____

Relationship to Patient (if representative): _____