ALLIANT DERMATOLOGY
Medical | Surgical | Cosmetic | Vein
Established 2012
(352) 399-7295

Dermatology
Mohs Surgery
Plastic Surgery
Vein Therapy
Cosmetic Dermatology
Radiation Oncology

Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

Patient's Name: _____ Date of Birth: _____

I understand that the protected health information specified below may include mental health, substance abuse, HIV/AIDS status information, diagnostic and treatment records.

I have read and understand the following statements:

1. I may revoke this authorization at any time by notifying us in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and under my own free will.
5. If necessary, I agree to pay charges to provide the information request.
6. I understand that unless otherwise revoked, this authorization will expire 1 year from today's date.

I hereby authorize Alliant Dermatology PA to:

___ Disclose to ___ Obtain from (for the purpose of: ____Treatment ____ Personal request)

Name: _____ Phone: _____ Fax: _____

Address: _____

Patient Signature: _____ Today's Date: _____

Please furnish the following information specified below:

____Complete medical record ____Pathology reports ____ Lab reports ____Operative reports ____

Other: _____

Please supply this information as soon as possible to:

Alliant Dermatology PA

8620 E County Road 466 The Villages, FL 32162