SOUTH SHORE DERMATOLOGY PHYSICIANS, P.C.

DEDICATED TO HEALTHY SKIN FOR LIFE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize_____ to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name_____Date of Birth_____
   Address_____
   Street City State Zip Code

3. Information to be disclosed to_____
   Name
   _____
   Street City State Zip Code

4. Disclose the following information for treatment dates _____ to _____ OR

   _____Complete Records _____ Laboratory _____ Pathology

5. The above information is disclosed for the following purposes:

   _____Medical Care _____Personal _____Legal _____Insurance _____Other

6. I understand I may revoke this authorization at any time by requesting such of the above referenced physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization expires on (upon) 1 yr from date Signed
   Date or Event

_____ _____
Signature of patient or legal representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient or authority to act for patient

This authorization shall be deemed invalid unless all numbered entries are completed

Fellow AAD Physicians Dedicated to Excellence in Dermatology™

31 ROCHE BROS. WAY, SUITE 200 • N. EASTON, MA 02356 • PHONE (508) 535-DERM (3376) • FAX (508) 535-3377 • WWW.SOUTHSHOREDERM.COM