Consent Forms

Dermatology Specialists of Omaha

Authorization to Use and/or Disclose Health Information

Patient Name: _____ Date of Birth: _____ Date: _____

Authorization. The undersigned hereby authorizes:

_____

_____

_____

and its employees to use and/or disclose to Dermatology Specialists of Omaha, for the following purpose(s):

_____ (may state "per my request")

the following health information:

( ) Complete medical record or,

( ) Medical records from _____ (date) to _____ (date) or,

( ) Specific medical records as listed: _____

including, if applicable, the following health information related to testing, diagnosis, and/or treatment for (please initial applicable line): _____ HIV (AIDS virus), _____ sexually transmitted diseases, _____ mental health, or _____ drug and/or alcohol abuse.

Conditions. We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

Further Uses and Disclosures. When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

Expiration. This authorization shall expire upon the earlier of _____ or one year from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law.

Revocation. You have the right to revoke this authorization at any time by providing us with written notice by certified mail, fax or hand delivery to the following address:

Dermatology Specialists of Omaha
Attn: Privacy Officer
909 N. 96th St., Suite 201
Omaha, NE 68114

When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

By signing below, you acknowledge receipt of a signed copy of this authorization.

_____ _____
Printed Name Date

_____
Signature

Note: If signed by someone other than the patient, we need written proof of your authority.