MGMD

ADVANCED SCIENCE FOR BEAUTIFUL SKIN

MGMD Dermatology ▪ Michele Grodberg MD

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

TODAY'S DATE:_____ PATIENT'S FULL NAME:_____

DATE OF BIRTH:_____ CELL PHONE NUMBER:_____

I authorize MGMD Dermatology to disclose the Protected Health Information described below to the following person(s) and/or entity (ies):

Name: _____

Address:_____

I authorize MGMD Dermatology (the "Practice") to disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as **pathology reports only (no charge)**, date(s) of service, types of services, level of detail to be released, origin of information, etc.) :

_____Dates of care included from _____ to _____

1. I understand that it may take up to 30 days to complete this request.

2. The Practice will provide copies of pathology reports from procedures done by the Practice at no charge. Typically, the Practice will charge $1.00 per page, up to a maximum of $50 for copies of medical records. The Practice reserves its right to impose charges for providing copies of patient treatment and billing records as provided for by New Jersey and Federal laws and regulations.

3. I understand that records from other medical facilities and/or doctors will NOT be included in this release unless specified.

4. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

5. I understand that MGMD Dermatology will not condition treatment or payment on my providing authorization for the requested disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

6. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of MGMD Dermatology. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, where other action has been taken in reliance on an authorization I have signed.

7. 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.

*EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now) _____.
(If no date is stated, this authorization expires six months from the date it was signed.)

_____ _____ _____

DATE SIGNATURE OF PATIENT/REPRESENTATIVE IF NOT PATIENT STATE RELATIONSHIP

106 Grand Avenue ■ Suite 330 ■ Englewood NJ 07631 ■ Telephone 201 567 8884 ■ Fax 201 567 5799
info@mgmdderm.com ■ www.mgmdderm.com