I.A. Tangoren, M.D., PLLC
Dermatology & Dermatologic Surgery
(315) 424-1430 FAX (315) 424-1779
www.drtangoren.com

AUTHORIZATION TO DISCLOSE

Patient Name: _____ DOB: _____

It is the policy of this practice not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, caretakers/babysitters, or any individual or organization you designate please indicate that below, so that we may best serve you.

I authorize I.A. Tangoren, M.D., P.L.L.C. (the physician and other providers and employees involved in my care, visits, billing and payment) to disclose my Personal Health Information (PHI) to the following individuals or organizations:

_____

_____

The purpose (s) for which the information will be used or disclosed:

_____

(If purpose is not designated we will infer "at the request of the individual"

This Authorization shall be in force and in effect until _____ at which time this Authorization to use or disclose this Protected Health Information shall expire. If a date is not provided, this authorization will remain in place until revoked or changed by the patient or the patient's representative in writing.

I understand that I have the right to revoke or change this Authorization, in writing, at any time by sending such written notification to the practice at its address above. I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the Protected Health Information.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law or the HIPAA privacy and security rules.

The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide Authorization for the requested use or disclosure.

I understand that this authorization will enable my health care provider to discuss any or all of my health-related information with the aforementioned individual (s) and/or organizations either over the phone, or face-to-face, including but not limited to, my HIV status, mental health and drug/alcohol use, and rehabilitation history.

_____

Patient Signature or Signature of Patient's Authorized Representative Date

If signed by Patient's Authorized Representative, please print name and describe the representative's authority to act for the patient:

_____/_____

Print Name of Patient or Patient's Authorized Representative / Reason for Authority to Sign on Patient's Behalf