Scott Darling, D.O., P.C.
Skin, Vein & Skin Surgery Center

Authorization of Use and Disclosure of Protected Health Information

I acknowledge that I have received the pamphlet "Notice of Privacy Policies and Practices" for this office and understand its contents.

Signature: _____ **Date:** _____

Disclosure of your information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" pamphlet requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred prior to this. You have the right to request restrictions on use and disclosure of your health information. Please notify the Privacy Officer if you want to do so.

Signature: _____ **Date:** _____

Persons Authorized to Receive Information: Dr. Darling's office may release health information collected and received about me to the following persons:

Name: _____ **Relation:** _____
Name: _____ **Relation:** _____
Name: _____ **Relation:** _____

Expiration Date of Authorization: This authorization is effective for six years unless revoked or terminated by the patient or patient's representative.
Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Dr. Scott Darling D.O., P.C. You should contact the Privacy Officer to terminate this authorization.
Potential for Redisclosure: The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

☐ I authorize the person(s) listed above to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided by Dr. Scott Darling D.O., P.C.

☐ I do not authorize the following information to be disclosed to any other parties except to me as the patient.

Name of Patient (please print): _____ **Date:** _____

Signature of Patient/Representative: _____ **Relation:** _____

Referring Doctor Release: I authorize my referring physician to receive any information regarding my illness and treatment.

Signature _____ **Date:** _____

Photography Permit: I hereby authorize the appropriate personnel of the office of Dr. Scott Darling to take pictures for the purpose of medical documentation. The pictures are only to be shown to duly licensed physicians, medical students and authorized paramedical personnel for teaching purposes.
Signature: _____ **Date:** _____