

## **Authorization of Use and Disclosure of Protected Health Information**

**Uses and Disclosures:** Disclosures of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies" brochure and/or consent require 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 before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

### **Persons Authorized to Receive Information:**

Health information NDDA collects or receives about you may be disclosed to the following persons:

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Name of person / relation / organization

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Name of person / relation / organization

### **Use and Disclosure of Information:**

\_\_\_\_\_ 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 at North Dallas Dermatology Associates.

\_\_\_\_\_ I do not authorize the following information to be disclosed to any other parties except to me as the patient. (Please Specify): \_\_\_\_\_

### **Potential for Re-disclosure**

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.

### **Signature**

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Name of Patient (Print or Type)

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Signature of Patient / Date

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Signature of Patient Representative

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Relationship of Patient Representative to Patient