Idaho Skin Surgery Center, P.C.
Mohs Micrographic & Dermatologic Surgery
Disorders of the skin, hair, & nails
Jared Scott, M.D.
Jessie Zimmerman, PA-C
Holly Wolf, PA-C

# *Authorization to Release Protected Health Information*

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

I authorize ("the Clinic") to use or disclose Protected Health Information ("PHI") contained in my medical records in the following manner:

**From:** _____
Physician/Institution that presently has data

_____
Street Address

_____
City State Zip Phone Fax

**To:** _____
Physician/Institution requesting data

_____
Street Address

_____
City State Zip Phone Fax

## Purpose of Release

( ) Treatment/Continued Care
( ) Application for Insurance
( ) Legal Purposes
( ) Personal
( ) Disability Determination
( ) Payment of Insurance Claim
( ) Other _____

## Information to be Released

( ) All of my health information
( ) Progress Note(s )
( ) Mole mapping/photography
( ) Laboratory Report(s )
( ) Pathology Report(s)
( ) Other _____

( ) I would like a copy of my protected Health Information. I understand that a copy of my records will be made available for pickup within 30 days after the date of receipt of the request and there will be a flat fee of $6.50. If my records are mailed, postage will be additional.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on authorization. Unless otherwise revoked, this authorization will expire 90 days from the date the authorization was signed. The facility, its employees, officers and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SPECIFIC AUTHORIZATION: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have signed here: _____

Signed: _____ Date: _____

Printed Name of Person Signing (If Not Patient) _____

Witness: _____ Date: _____

Revised on 4/26/2017