LONE PINE
DERMATOLOGY AND MOHS SURGERY

DR. CORY MAUGHAN | HEATHER ALLRED, PA-C

HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Phone Number: _____ Email:_____

I authorize the following using or disclosing party, to use or disclose all of my medical records including labs, and pathology.

Released By:

Name:_____

Address:_____

_____

Phone:_____

Fax:_____

Email:_____

Release To :

Lone Pine Dermatology

517 W. 100 N. Ste #103

Providence, UT 84332

PH: (435) 554-8442

FAX (435) 500-9167

LonePineDerm@gmail.com

I understand that Lone Pine Dermatology is committed to protecting my privacy and personal information. In order to best fulfill this responsibility, they only share private health information with authorized individuals.

I understand that I have the right to revoke the authorization in writing at any time. I also understand that my treatment is not conditioned on whether or not I sign this authorization. I understand that any information disclosed per this authorization may be re-disclosed by a recipient and is no longer protected by federal or state health privacy laws. Unless otherwise revoked, this authorization will expire 1 year from the date signed. I understand that authorizing this disclosure of my health information is voluntary. I can refuse to sign this authorization.

_____

Signature of Patient or Authorized Representative Date