GIBSON DERMATOLOGY
4200 Rodney Parham, Suite 202
Little Rock, AR 72212
Phone: (501) 227-4323 Fax: (501) 227-4149

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize the use/disclosure of my health information as described below:

Who is authorized to use/disclose the information: _____

_____

Who is authorized to receive the information: _____

_____

Description of information that may be used/disclosed, and the dates of such information (for example, nurses notes from 01-01-18 to 01-15-19) _____

_____

The information will be used/disclosed for the following purposes: _____

_____

I understand that if the person or entity who receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that the providers at Gibson Dermatology will be paid for the costs of copying the information to be released.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to the providers of Gibson Dermatology, except to the extent that action has been taken in reliance on this authorization. This authorization expires ninety (90) days from the date it is signed below.

X _____
SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

X _____
PRINTED PATIENT'S NAME DATE OF BIRTH

X _____
NAME OF PERSONAL REPRESENTATIVE (IF APPLICABLE) RELATIONSHIP TO PATIENT

_____
WITNESS DATE