RIVERGATE DERMATOLOGY, PLLC
201 BLUEBIRD DR.
GOODLETTSVILLE, TN 37072

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO TO THIRD PARTIES

By signing this authorization, I authorize:

_____
(Physician/Clinic the patient is requesting records **from**)

_____

_____

to disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits the above named physician/clinic/health care provider, to disclose to

Rivergate Dermatology, PLLC
201 Bluebird Dr.
Goodlettsville, TN 37072
615-859-7546/fax 615-851-7760

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____
_____

If you do not want certain portions of your medical records released, please initial the spaces below. Leave blank if this does not apply to your request.

____AIDS/HIV _____SUBSTATNCE ABUSE _____PSYCHIATRIC CONDITIONS _____OTHER (PLEASE SPECIFY)

This authorization will expire on _____ .
{Expiration Date or Defined Event}.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the above named physician/clinic/health care provider has acted in reliance upon this authorization.

Signed by:_____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name — Date

_____ _____
Patient's Date of Birth — Patient's Current Phone #