# TDC Release of Information

## Authorization to Use and Disclose Protected Health Information

**PLEASE COMPLETE THE FOLLOWING INFORMATION:**

Patient Name: ___________________________________________________________________________

SSN: ____________________________________________Date of Birth: ________/__________/___________

Address: ________________________________________________________________________________

Phone# _________________________________________________________________________________

**INFORMATION TO BE RELEASED FROM**: _________________________________________________

**PLEASE SEND INFORMATION TO:**

Name: ___________________________________________________ Phone# _________________________

Address: _________________________________________________ Fax# ____________________________

_________________________________________________

**PURPOSE OF DISCLOSURE:** ___ Treatment or Consultation ___ at the request of the patient

____ Billing or claims payment ___ Other (Specify) _____________________________________________

The Treatment dates covered by this authorization are from: ___________________ to ___________________

**Please check type of information to be released:**

__All records __ Laboratory/Pathology Report __ Progress Notes __ Billing Statement

__ Other ______________________________________________________________________

**I understand that the information disclosed may contain testing or treatment information relating to Mental Health: Drug and/or Alcohol Abuse Treatment; Sexually Transmitted Diseases; HIV/AIDS virus.**

**I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations.**

**I understand that this authorization will expire in 180 days from the date signed below, unless otherwise specified. I understand that this form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing,**

**I understand that refusal to sign this authorization does not condition Treatment.**

______________________________________________________________________________________

**Signature of Patient or Representative** **Relationship** **Date**

P. Craig Stites, MD| G. Luke Lewis, MD
Matt Patton, MS, MPA, PA-C| Bryce Bass, PA-C| Melanie Myers, PA-C
7900 Dallas Street * Fort Smith, AR 72903 | 479-242-6647 (MOHS) | www.thedermcenterfs.com