AUTHORIZATION FOR USE OR RELEASE OF YOUR HEALTH INFORMATION

Attn: Privacy Officer
Dermatology Associates of Kentucky, PSC
250 Fountain Court
Lexington, KY 40509

Patient Name (print): _____ Date of Birth: _____

Phone Number: _____ DAK Provider Name: _____

I authorize Dermatology Associates of Kentucky, PSC (DAK) to use or disclose my health information as described below.

❑ I am requesting records to be sent TO DAK ❒ I am requesting records to be sent FROM DAK

Person or organization sending/receiving the information:

Name: _____

Fax: _____ Phone: _____

Address: _____

What: Specific description of information (including date[s] if appropriate):

_____

Why: Specific description of the purpose of the use or disclosure:

_____

I understand that this authorization is voluntary. If I do not sign this form, my healthcare from the Dermatology Associates of Kentucky and the payment for this healthcare will not be affected.

I understand that once my information is released, it may no longer be protected by federal privacy regulations.

I understand that I may see and copy the information described on this form if I ask for it, and I will get a copy of this form after I sign it.
I understand that this authorization will expire: _____

I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by notifying DAK's Privacy Officer in writing. But if I do, it won't have any effect on actions DAK took before the revocation was received.

_____
Signature of patient or patient's representative Date
(Do not sign until the information above is filled in completely.)

Printed name if patient's representative: _____

Relationship to patient: _____