HENNING DERMATOLOGY GROUP

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider

_____ (insert practice/ doctor you wish to obtain records FROM) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: Henning Dermatology Group

Address: 150 North Finley Ave Suite 205 Basking Ridge, NJ 07920-1686

Purpose: I authorize the release of my health information for the following specific purpose: **upon request of the patient for continued care.**

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

X Only the following records or types of health information: All biopsies, All MOHS reports and diagrams, lab work within the last 12-months, all office notes within the last 12-months

Term: I understand that this Authorization will remain in effect:
- ☐ From the date of this Authorization until the _____ day of _____, 20___.

X Until the Provider fulfills this request.
- ☐ Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Henning Dermatology Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: **I may contact Henning Dermatology at 150 North Finley Ave Suite 205 Basking Ridge, NJ 07920-1686 or by telephone at:**

Patient Name: _____ Date of Birth:_____

Signature: _____ Date: _____

If patient is a minor or unable to sign:

Name of Guardian: _____ Relationship: _____
Signature: _____Date: _____

NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.