

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

**Steelecreek Dermatology**

**11040 S. Tryon St. Suite 203 Charlotte, NC 28273 (P)704-587-3200 (F) 704-587-0044**

This form authorizes \_\_\_\_\_ to communicate information about my care (e.g., appointments, labs, medication, treatment plans, billing information) to \_\_\_\_\_ (medical office receiving documents).

**Patient Name:** \_\_\_\_\_  
(Last) (First) (Middle Initial)

**Date of Birth:** \_\_\_\_\_ **Primary Contact Number:** (\_\_\_\_\_) \_\_\_\_\_  
mm/dd/yyyy  Home  Cell\*  Work

**Mailing Address:** \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City) (State) (Zip)

**COMMUNICATING WITH YOU**

PHONE

DETAILED MESSAGES PERMITTED

- |                                                                                                                                             |                                          |                                                      |                               |
|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------|-------------------------------|
| <input type="checkbox"/> Primary Contact Number Above                                                                                       | <input type="checkbox"/> via text (SMS)* | <input type="checkbox"/> voicemail/answering machine | <input type="checkbox"/> None |
| <input type="checkbox"/> Other: (_____) _____<br><input type="checkbox"/> Home <input type="checkbox"/> Cell* <input type="checkbox"/> Work | <input type="checkbox"/> via text (SMS)* | <input type="checkbox"/> voicemail/answering machine | <input type="checkbox"/> None |
| <input type="checkbox"/> Other: (_____) _____<br><input type="checkbox"/> Home <input type="checkbox"/> Cell* <input type="checkbox"/> Work | <input type="checkbox"/> via text (SMS)* | <input type="checkbox"/> voicemail/answering machine | <input type="checkbox"/> None |

EMAIL

- \_\_\_\_\_
- All information from this practice\*  Data breach notifications
- Billing and appointment information only (no treatment information)

\* By checking this box, you confirm that you understand that email and standard SMS messaging are not confidential and are unsecure methods of communication. You also understand that sending your health information via email and standard SMS presents a risk that a third party could intercept and read your information. This practice does not recommend communicating healthcare information via email or standard SMS.

**COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS**

This practice may orally communicate to the family members, friends, or caregivers listed below. Check the box next to each type of information this practice may share.

- All information  Prescriptions  Appointments (request/confirm/cancel)  Billing/Insurance

Spouse/Partner: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
First and Last

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
First and Last First and Last

This practice may **NOT** communicate with my family members, friends, or caregivers.

### YOUR PHOTOS & MULTIMEDIA

- Photo received from you or personal representative
- Photo taken by staff (e.g., pre/post procedure)
- Other clinical images (e.g., X-ray)
- Other: \_\_\_\_\_

### Photos/Images may be posted:

- In office
- On office's website
- Other: \_\_\_\_\_

### ACKNOWLEDGEMENT AND SIGNATURE

- You acknowledge that information related to a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse might be included in a communication you authorize on this form. Information that has been shared as permitted by this form may be redisclosed and no longer protected by state or federal privacy laws.
- You can revoke or stop the communications on this form at any time in writing. It will not apply to any communications that were made before our practice received your written notice to stop the communications.
- An Authorization to Release Health Information or Patient Access Request must be completed for this practice to provide copies of or transmit your health information/records to anyone other than you.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative.

Patient/Personal Representative Signature

Date mm/dd/yyyy

Description of Personal Representative's Authority (attach necessary documentation if not previously provided)

### FOR OFFICE USE & REFERENCE ONLY

This authorization has been revoked: \_\_\_\_\_

The revocation/cancellation must be in writing and filed with the original authorization.

Date original signed authorization received: \_\_\_\_\_

Copy provided to patient/personal representative

Notes: \_\_\_\_\_

