PLLC

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ____ DOB: _______________
_________________________ Previous Name: _______________________________________

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Doctor's Name/Practice: ____
Address: ____
Phone: ____ Fax: ___________________________

I request and authorize the above listed doctor and practice to release health information of the patient named above to:

Rachel Garner, M.D. / Cayuga Dermatology, PLLC
821 Cliff Street, Suite 2, Ithaca, NY 14850
Phone: 607-379-6229 Fax: 607-882-7618

This request and authorization applies to healthcare information relating to the following treatment, condition or dates of treatment (select one or more of the following):

☐ All pathology reports, the last office note, and the last full skin check note

☐ ____

☐ All healthcare information

This authorization expires one year after it is signed; or when the following event occurs: _________________

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Healthcare Information" or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my healthcare information. My letter must include the name or other specific identification of the person(s) that no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out information that I wanted released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect that information.

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Signature of patient or patient's authorized representative Date signed:

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Relationship to patient if signed by parent, guardian or other representative