CYPRESS DERMATOLOGY

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HIPAA AUTHORIZATION FORM

(permission from patient/patient's legal guardian to share personal medical information)

Patients Name: _____
DOB: _____
Street Address: _____
City, State, Zip: _____

I_____, hereby authorize Cypress Dermatology And/or any medical facility to release any and all medical information and test results that pertain to me, to the following individual(s):

Name: _____Phone#:(____) _____-_____Relationship to pt._____
Name: _____Phone#:(____) _____-_____Relationship to pt._____
Name: _____Phone#:(____) _____-_____relationship to pt._____

I authorize Cypress Dermatology or the medical facility to contact the individual(s) listed above to convey any pertinent information to me.

I understand that I may revoke/cancel this authorization by notifying Cypress Dermatology in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____
(Signature of patient) **Date**
Or if applicable-

_____
Signature of Legal Guardian or Personal Rep of Patients Estates _____
Date

_____
Description of Authority to Act for the Patient _____
Date

_____ _____ _____
Name of Witness **Witness Signature** **Date**