Brummitte Dale Wilson, M.D. & Associates
Dermatology, Mohs Surgery, Aesthetic & Laser Surgery
Brummitte Dale Wilson, M.D. * Cornelie M. Jones, M.D. * Peter SantaLucia, M.D.
Certified by the American Board of Dermatology

Authorization for the Use or Disclosure of Protected Health Information to a 3rd Party

As required by the Health Insurance Portability and Accountability Act of 1996 Brummitte Dale Wilson, M.D. & Associates may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, ______________________________ (print name) hereby authorize the ☐ **use** ☐ **disclosure** ☐ **use and disclosure** of the following health information that pertains to me **[REQUIRED]**

75¢ per page (+ postage) **for one of the options listed below:**

☐ Relevant Records deemed pertinent by your treating physician(s) from our Practice
☐ Pathology Reports - please specify biopsy/excision site __________ & approximate Date _____/_____/_____
☐ Progress Notes - please specify Date Range _____/_____/_____ through _____/_____/_____
☐ Other - please specify type of disease, accident, specific dates of treatment, or other portion of records in which you are interested

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for the following purpose(s): **[REQUIRED]**

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____

I authorize the following persons to make these disclosures of my health information: **[REQUIRED]**

____

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I authorize the following persons to receive these disclosures of my health information: **[REQUIRED]**

____

____

Hamburg Medical Park • 17 Long Avenue, Suites 200 & 201 • Hamburg, New York 14075 • Phone: (716) 648-2770 • Fax: (716) 648-1552
www.BDWilsonMD.com

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Privacy Officer, Brummitte Dale Wilson, M.D. & Associates, 17 Long Avenue, Suite 200, Hamburg, NY 14075. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I would like this authorization to expire on _____/_____/20____. (**this authorization will automatically expire in 60 days if this field is left blank**).

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that Brummitte Dale Wilson, M.D. & Associates may receive compensation for the uses and disclosures that I have authorized.

________________________________ ________________________________

Signature of Patient [REQUIRED] Date **[REQUIRED]**

WITNESS [REQUIRED] State of ___________ County of __________

On this ________ day of ___________________, 20_____, before me personally came ___________________ ___________________________ known to me to be the individual above named who executed the foregoing authorization, and who duly acknowledged to me the execution thereof.

____ _____/_____/20/_____

Signature Of Witness [REQUIRED] **Date [Required]**

REVOCATION SECTION

I hereby revoke this authorization.

________________________________ ________________________________

Signature Date