HIPAA Authorization Form for Family/Friends

**Authorization to Release Medical Information**

I hereby authorize Russell Dermatology of Conway to release or disclose all my medical records to the below named recipient(s).

Patient Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.**

\_\_\_\_ Substance Abuse \_\_\_\_ Psychological or Psychiatric Treatment \_\_\_\_ HIV/AIDS/STD

This authorization shall be effective until (check one):

 I submit a change in writing

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, unless I revoke it in writing prior to this date.

I understand that I am entitled to a copy of Russell Dermatology of Conway’s Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website www.russelldermatology.com or from the office directly.

