MIDWEST DERMATOLOGY

4242 Farnam St. Suite 360, Omaha, NE 68131, **402-933-0800** Fax **402- (531) 721-2918.**
Jason S. Papenfuss MD ● Justin G. Madson, MD, PhD ● Melissa D. Darling, MD ● Collin R. Parker, M.D.

Authorization to Use and/or Disclose Protected Health Information

Patient: _____ Date of Birth: _____

Phone # _____

I authorize and request employees of **Midwest Dermatology Clinic, PC** to release the stated information to the specified parties named below. I understand that this authorization will be considered valid and active for six months upon which time it will be inactivated. I understand I have the right to revoke this authorization in writing at any time. I understand that the revocation will not apply to those disclosures that have already been made.

Reason for release (may use "per my request") _____

Please include the following information:

Complete Medical records _____
Blood Test results _____ from (date) _____to _____
Pathology Test Results _____ from (date) _____ to_____

Other _____
Including, if applicable, the following information related to testing, diagnosis, and/or treatment for (please initial applicable line): _____HIV (AIDS virus), ____sexually transmitted diseases, ____mental health, or ____drug/and or alcohol abuse.

Requesting the Release From

Midwest Dermatology Clinic, P.C.

_____
(Physician Name)

Information to be released to:

To: _____

Address: _____

City: _____ State: _____ Zip:_____

Signature _____ Date _____

Witness _____ Relationship to Patient _____