Dermatology of the Berkshires pc
VICTORIA R. CAVALLI, M.D. BOARD CERTIFIED DERMATOLOGIST
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Medical Records Release
Protected Health Information Release Authorization

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

This will authorize _____ to use or disclose my protected health information/medical records to _____ for the purpose of _____.

( ) Complete copy of medical records

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I understand that I may inspect or copy the protected health information described by this authorization.

I understand that this authorization may be revoked in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Dermatology of the Berkshires, P.C., 77 Main Street, Suite 200 North Adams, MA 01247.

I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protect by the federal HIPPA Privacy Rule.

I understand that I do not have to sign this authorization in order to receive treatment from Dermatology of the Berkshires, P.C. In fact, I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

This authorization will expire on _____ (not longer than 1 year). If no date or event is stated, expiration is six months from the date it was signed.

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION