RUSTAD DERMATOLOGY PC

Troy Rustad MD – Elliott Rustad MD

Authorization to Disclose Protected Health Information

Please take a moment to read through the protected health information handout included with your patient paperwork.

_____ _____

Patient Name Date of Birth

I request and authorize Rustad Dermatology to disclose the protected health information (PHI) of the above named patient to the following individual(s):

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Rustad Dermatology PC, Attn: Privacy Officer, 1919 South 40th Street, Suite 330, Lincoln, NE 68506. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 3 (three) years from the date signed below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used to disclose as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at (402) 484-6222.

_____ _____

Patient or Legal Guardian Signature Date