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**Tarrant
Dermatology**
CONSULTANTS

**Dermatology
Associates**
of Parker County

Laura White, PA-C
Lauren Harr, PA-C
Sonya Tanna, PA-C

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Maiden Name: _____ Social Security #: _____

I request and authorize **TARRANT DERMATOLOGY CONSULTANTS, P.A.**
to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating only to the following treatment, condition, or dates:

All healthcare information

Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

In general, The HIPAA privacy rule gives individuals the right to question a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of, disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures may be permitted without prior consent in an emergency.