

Authorization for Release of Protected Health Information (PHI)

There are times when you may want your PHI released to other individuals like a spouse, parent, guardian, or advocate. Because your records are confidential, we will need your signed consent to release your PHI. This authorization is effective until revoked or modified by patient.

Parents/Guardians: In order to speak with you on behalf of your dependent child (over the age of 18) about their PHI we are required to have their written consent.

South Jersey Skin Care & Laser Center, P.C can share my PHI with the following people:

First Name: _____
Last Name: _____
Best Contact Number: _____
Relationship to patient: _____

First Name: _____
Last Name: _____
Best Contact Number: _____
Relationship to patient: _____

By signing this form, I authorize South Jersey Skin Care & Laser Center, P.C. to use or disclose the following information (check all that apply).

- All of my health information
- Information regarding medications and prescriptions
- Information biopsy and lab results
- Information regarding billing and insurance

Signature _____

Print Name _____

Date _____

This form may be submitted through fax at 856-810-9889 or provided in person.