Authorization for Release of Patient Information

Patient Identification	Name: _____ Date of Birth: _____ Address: _____ City-State-Zip: _____ Phone: _____
Who is releasing information?	Gaul Dermatology PO Box 1144 Spencer, IA 51301 Phone: (712) 262-6906
Who receives the information? *Check ONE box*	**Please choose ONE option only please** ☐ Courtney Bolluyt, PA-C ☐ *Yourself – Send self addressed **stamped** envelope with extra postage with this form* ☐ Or other Provider/ Entity: _____ Address: _____ City-State-Zip: _____ Phone: _____ Fax:`_____
Information to be disclosed	☒ Records needed for continuing care ☒ Demographics information including address, phone and insurance
Purpose of disclosure	☒ Continuing Medical Care
Expiration Date	This authorization will expire one year from the date of signature or on _____
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the provider noted above. However, the revocation is not valid if action was previously taken in reliance on the authorization.
Authorization	I hereby authorize Gaul Dermatology to disclose the protected health information concerning the above named patient to the party identified in the section entitled "Who receives the information". I understand that once the information is disclosed it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment. You may revoke this request in writing at any time. _____ _____ *signature of patient* *Signature Date* or _____ _____ *signature of POA – (requires documentation of POA)* *Printed name of POA*

For Office staff to complete	
Completion of Request	Date Completed: _____ How Completed: Mail Fax Who completed? _____