TOLL FREE
844-4RENEWME

OFFICE
970-409-4000

info@renewdermatology.com
www.renewdermatology.com

Renew DERMATOLOGY
"Renew The Skin You're In"

PHYSICAL ADDRESS
60 MAIN STREET, STE H
FRISCO, CO 80443

MAILING ADDRESS
265 DILLON RIDGE RD, STE C402
DILLON, CO 80435

RENEW DERMATOLOGY AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize Kelly Ballou, PA-C and any staff member of Renew Dermatology to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient(s): I authorize my health care information to be released to the following recipient(s):

1. Name & Relationship to Patient: _____
Mailing Address/Phone #: _____

2. Name & Relationship to Patient: _____
Mailing Address/Phone #: _____

Information to be disclosed: I authorize the release of the following health information: (Please indicate your choice below with an "X")

_____All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, referrals, and any treatment received by me.
_____Appointment times and dates
_____Only the following records or types of health information: _____

Term: I understand that this Authorization will remain in effect:
(Please indicate your choice below with an "X")

_____From the date of this Authorization until the _____ day of _____, 20___.
_____Until the Provider fulfills this request.
_____Until the following event occurs: _____
_____Indefinitely unless I revoke this authorization in writing to Renew Dermatology.

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I authorize Kelly Ballou, PA-C to send pictures via text or email to consult on my case with her supervising physician if needed, using every available option to maintain privacy of my identity. YES or NO

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Renew Dermatology. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Renew Dermatology at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the Renew Dermatology office for answers to my questions about the privacy of my health information at 60 Main Street, Suite H, Frisco, CO 80443, or by phone at (970) 409-4000.

_____ _____ _____

Signature Date Signature of Witness

_____

Legal Name (Print)

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____

Name of Guardian/ Representative Legal Relationship Date