Beautiful You DERMATOLOGY

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310 Lake Street South
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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____Date of Birth: _____
Address: _____Phone Number: _____

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider

_____ (insert name of provider/clinic)
to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

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

Name of Provider: **Crista Wenisch, DCNP** @ Beautiful You Dermatology (BYD)
*See above for address *Fax number: 763.247.0200

Purpose: I authorize the release of my health information for the following specific purpose:

_____
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ 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 and any treatment received by me.
- ❑ Only the following records or types of health information: _____
- ❑ **Term:** I understand that this Authorization will remain in effect until the provider fulfills this request.

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 USC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to BYD 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 BYD for answers to my questions about the privacy of my health information at 310 Lake Street South; Big Lake, MN 55309 or by telephone at (320) 204-4858.

Signature of Patient or Guardian/Representative	Legal Relationship	Date
_____	_____	_____