Academic Dermatology
51221 Schoenherr, Suite 201
Shelby Township, MI 48315

Individual Patient Authorization

This form is provided to confirm your authorization to use or disclose your protected health information for a special purpose.

Patient Name: ______________________________
Address: ______________________________
Phone Number: ____________________ DOB: ______________
SS# ____________________

I give my permission for my protected health information to be given as indicated below and as indicated in the Privacy Notice which has been given to me:

- ☐ Lab and other test results
- ☐ Diagnosis
- ☐ Information about my condition and or treatment.
- ☐ All information can be given or discussed
- ☐ Other information described here ______________________________

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My information can be given only to the person or persons listed below.

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I understand that I may revoke this authorization at any time by giving a written notice to the Privacy Officer at this office. However, I understand that I may not revoke this authorization for any actions taken prior to receipt of my written notice to revoke this authorization.

I have had a chance to read and think about the content of this authorization form and I agree with the statements made in this authorization. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature ______________________________ Date ______________