SPECIFIC AUTHORIZATION

I hereby give my authorization for CONWAY DERMATOLOGY CLINIC to use or disclose my Protected Health Information to carry out treatment, payment or any other health care operations.

I understand that my Protected Health Information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that Dr. Hudson created, received from me, received from another Health Care Provider, a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give Dr. Hudson authorization to use or disclose my Protected Health Information to other health care providers, group health plans, and business associates to provide for my medical care, treatment, and evaluation; the payment of my medical care, treatment and evaluation; and to provide information for utilization and quality care purposes.

I understand that I have the right to revoke my authorization, however, it shall not be considered revoked to the extent Dr. Hudson has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information. This authorization shall remain in effect until I revoke it in writing.
I also understand that Dr. Hudson can condition my treatment or evaluation on my signing this authorization.

I understand that I have the right to request, in writing, to inspect any copy of my Protected Health Information. There are a few exceptions to this rule. Dr. Hudson must approve or deny my request within 30 days and in the case of denial, provide me with an explanation of the reason. Dr. Hudson may charge a reasonable fee for the preparation of the information needed and the fee must be prepaid.

I understand the law requires CONWAY DERMATOLOGY CLINIC to have privacy protections for Protected Health Information and to give notice of its legal responsibilities to individuals. CONWAY DERMATOLOGY CLINIC has to follow the terms and conditions contained in its Notice of Privacy Practices, but retains the right to make retroactive changes to its Notice of Privacy practices.

_____ _____

Patient Date

_____ _____

Personal Representative Date