FARRELL PLASTIC SURGERY & LASER CENTER, P.C.
FARRELL LASER & COSMETIC MEDICINE CENTER
2025 Technology Parkway, Suite 204 Mechanicsburg, PA 17050
Phone 717-732-9000 Fax 717-732-9011

Authorization to use or disclose protected health information

I hereby authorize the use or disclosure of the named individual's health information as described below:

_____ _____ _____
Patient Name Date of Birth Social Security #

_____ _____
Address (street, city, state, zip code) Telephone #

Farrell Plastic Surgery & Laser Center, P.C. and Farrell Laser & Cosmetic Medicine Center is authorized to make the disclosure to the following individual or organization:
Name: _____ Address: _____

☐ Pick up medical records myself in the office
☐ Fax to the above name and address fax # _____
☐ Mail medical records to the above name and address (a mailing fee will be charged)

_____ _____
Treatment Dates Purpose of Request

The following information is to be disclosed: (please check box for each item to be disclosed)

☐ Physician notes ☐ Lab results
☐ Pathology reports ☐ Photographs
☐ Complete records ☐ Other _____

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.
Re-disclosure: I understand any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.
Other rights: (A) I understand that authorizing the disclosure of this heath information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research may be denied. (B)I understand that I may inspect or obtain a copy of the information to be used or disclosed.
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (if I do not specify an expiration date, event, or condition, this authorization will not expire.
_____

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by legal representative, relationship to patient