MD | MITTAL DERMATOLOGY

HIPAA Authorization for Release of Information and Permission to Communicate with Parent/Guardian

Patient Name: _____

Date of Birth: _____

I, the undersigned patient, authorize Mittal Dermatology and its staff to disclose, discuss, and communicate my protected health information, including medical records, appointment information, billing information, treatment plans, prescriptions, and other healthcare-related matters with:

Parent/Authorized Person Name: _____

Relationship to Patient: _____

Phone Number: _____

Email Address: _____

I understand that this authorization is voluntary and that I may revoke it at any time by providing written notice to Mittal Dermatology. Revocation will not apply to information already disclosed prior to receipt of the written revocation.

This authorization will remain in effect until:

☐ I revoke this authorization in writing

OR

☐ Expiration Date: _____

Patient Signature: _____Date: _____

Witness/Staff Signature: _____Date: _____