ROBERT GRIESHABER, M.D.

GRIESHABER DERMATOLOGY
BOARD CERTIFIED DERMATOLOGISTS

EMILY GRIESHABER, M.D.

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____ to use and/or disclose certain
Practice Name

protected health information (PHI) about me to _____. This authorization
Name of entity to receive this information

permits _____ to use and/or disclose the following individually identifiable
Practice Name

health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____
Expiration Date or Defined Event

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name/Date of Birth — Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION