CLEARVIEW DERMATOLOGY
The Clear Path to Healthy Skin

Steven A. Franks, MD
Shiu-chung Au, MD
Steven Smith, MD
Jessica Cosenza, PA-C
Eileen Cheever, PA-C

Susan Salander, PA-C
Abigail Engel, PA-C
Alice McCarthy, PA-C
Laura Helsing, PA-C

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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

Patient Name;		Patient Date of Birth;	
Street Address			
City, State, Zip		Patient Phone Number	( )

The folowing individual or organization is authorized to make this disclosure;

- ☐ Clearview Dermatology,LLC (aka Leominster Dermatology LLP) may disclose protected health information (PHI) of the above named patient to the individual and/or organization listed below;
- ☐ The individual and/or organization listed below may disclose protected health information (PHI) to Clearview Dermatology, LLC on behalf of the above named patient.

Name of individual or organization;					
Mailing address;					
Phone Number;	( )		Fax Number;	( )	
Records may be;	☐ Mailed to Above		☐ Faxed to Above		☐ Electronic Copy
Purpose of release of PHI	☐ Patient Access	☐ Transfer out of practice	☐ To health or other insurance	☐ Attorney	☐ Other_____ _____

Time Period to be sent	**All dates of service; _____**	**Date Range;_____**	**Specific Date(s);_____**	**Other;_____**
Records Requested	**All _____**	**Office Notes Only_____**	**Labs Only_____**	**Other;_____**

Initial below if you DO NOT want the following items, which may appear in your records, be authorized for use and/or disclosure.

___HIV/AIDS related information and/or records
___Psychotherapy notes
___Other mental health information, communications and/or records
___Information acquired by any social worker consulting me in their professional capacity.
___Contain communications between myself and any psychotherapist, psychologist, or allied mental health professional.
___Genetic testing information and/or records
___Contain any blood alcohol test results
___ Relate to venereal disease
___ Regard a child born out of wedlock

I understand that any item NOT initialed MAY be contained in my medical record released with this request INITIAL;_____

I understand as the patient or person authorized to act on the patient's behalf the following applies;

- I am entitled to receive a copy of this authorization, and the requester may be provided a copy of this authorization.
- I am entitled to inspect my records and that a reasonable fee may be charged for the records.
- I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality.
- I understand that Clearview Dermatology, LLC does not, and cannot control how a recipient uses or shares any information provided to the recipient in accordance with the authorization and that the recipient may not be bound by the same obligations as Clearview Dermatology, LLC
- I understand that my treatment, and receipt of services at Clearview Dermatology, LLC will not be affected by signing this form, or refusal to sign this form.

I hereby release Clearview Dermatology, LLC (and subsidiaries), its professionals, employees and agents from all liability arising from this authorized disclosure of my health information. Unless otherwise revoked, this authorization will remain in effect from the of this Authorization for one year, unless otherwise indicated. I understand there may be a fee involved for the reproduction of the requested health information. The fee charged, as allowed by applicable Massachusetts law, may vary depending on the number of pages being copied.

Signature of Patient or Representative;_____ Date;_____

Print Name & Relationship if other than Patient;_____

****Patients over age 18 must sign on their own behalf.**