HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information From DrUMD to Rocky Mountain Dermatology

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Address: ____

City, State, Zip: ____

Patient Telephone Number: ____________________ **Social Security Number:** ______________

DrUMD Medical Record Number: ______________________________________

(Note: Providing your social security number is voluntary but may be necessary to accurately identify your medical records. Failure to provide this information may delay release and/or receipt of your medical record(s).

I. Authorization

I authorize **DrUMD** (Larry E. Urry, M.D., Tyler Newman, P.A., and/or Allyx Bowthorpe, APRN) of 434 E 5350 S Suite D Ogden, UT 84405 and/or 950 E Medical Drive, Brigham City, UT 84302 to use and disclose the protected health information described below to **Rocky Mountain Dermatology** of 1760 North 200 East, North Logan, UT 84341

II. Effective Period

This authorization for release of information covers the period of healthcare **from January 1, 2010 to December 31, 2017.**

III. The purpose or need for this disclosure is the merging of the Ogden and Brigham City locations of DrUMD with Rocky Mountain Dermatology.

IV. The information to be disclosed from my health record:

- ☐ Only information related to (specify)
  ____
- ☐ Only the period of events from __________ to __________
- ☐ Other (specify) ______________________________________
- ☐ Entire Medical Record

I understand that I may revoke this authorization in writing submitted to any office of DrUMD, except to the extent that action has been taken in reliance of this authorization.

Signature of Patient:	Date:
Signature of Patient's Representative (Required if Patient is a Minor) Relationship of Patient's Representative to Patient:	Date: