

SOUTH COAST DERMATOLOGY  
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SUSAN DECOSTE, MD

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**Authorization for Release of Information**

I, \_\_\_\_\_ D.O.B. \_\_\_\_\_ authorize Dr. \_\_\_\_\_  
to disclose and or release my health information to:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Tel \_\_\_\_\_ Fax \_\_\_\_\_

The dates of information to be released are \_\_\_\_\_ to \_\_\_\_\_  
Information to be released consists of \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The purpose of this information is \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient or patient representative, please initial all following statements:

- A. I understand that Dr. \_\_\_\_\_ will not condition my treatment and if applicable, my payment, enrollment in health plan, or eligibility for benefits on whether I provide authorization for use or disclosure except in limited circumstances (e.g. if the treatment is search related, or health information for exams for school, camp, and employment purposes.

INITIALS \_\_\_\_\_

- B. I understand that I may revoke this authorization at any time by notifying Dr. \_\_\_\_\_ in writing prior to the release of information.

INITIALS \_\_\_\_\_

- C. I understand that the information used or disclosed pursuant to this authorization may be Subject to redisclosure by the recipient and may no longer be protected by federal privacy Regulations

INITIALS \_\_\_\_\_

D. I understand that I may see and copy the information described on this form if I ask for it,  
And that I get a copy of this form after I sign it.

INITIALS \_\_\_\_\_

E. I understand that this authorization is voluntary and that I have the right to refuse to sign  
This authorization

INITIALS \_\_\_\_\_

F. I understand that this authorization will expire on \_\_\_\_\_  
Date

\_\_\_\_\_ Date \_\_\_\_\_  
Signature patient or representative (you may refuse to sign this authorization)

PHYSICIAN, PLEASE COMPLETE IF AUTHORIZATION IS FOR MARKETING.

1. What is the purpose of the use or disclosure? \_\_\_\_\_
2. Will the physician requesting the authorization receive financial or  
In-kind compensation or exchange for using or disclosing the health information?

\_\_\_\_\_yes

\_\_\_\_\_no

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_