Franklin Dermatology Group

740 Cool Springs Blvd, Suite 200
Franklin, TN 37067
615-771-1881 (Telephone) 615-771-0050 (fax)

School/Work Excuse

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ____Date of Birth: __________________

I hereby authorize **Franklin Dermatology Group** to release or disclose to the below-named recipient(s) my protected health information (PHI) as it pertains to the item(s) marked below.

_____Appointments _____Released From Care _____Date of Visit

_____Reason for Visit _____Diagnosis

Entity/person authorized to receive this information:

____
(Name of Entity/Person)

____
(Street Address – City/State)

_____________________ _______________________
(Contact Number) **(Fax Number)**

Reason PHI is being used or disclosed:

____School/Work Excuse _____To verify restrictions _____Verify return to school/work

This authorization allows Franklin Dermatology to fax or mail this information to the designated entity/person. This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose this PHI information expires.

_____No longer in school ____Employment terminated _____Released from care

I understand I have a right to revoke this authorization by written notification to the Privacy Officer. The form of revocation will be provided upon request. PHI that was released prior to revocation of this authorization may not be revoked. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules.

____
Signature of Patient or Authorized Representative Date Signed

____
Relationship to Patient

01/03/2014