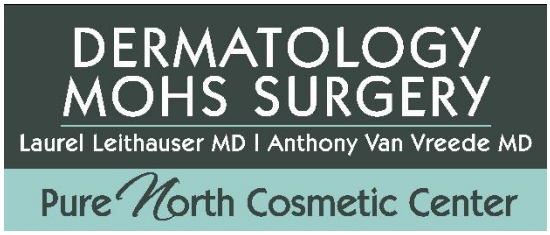
Patient Name:_____ Patient Date of Birth:_____



Laurel Leithauser, MD
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HIPAA CONSENT FORM

By listing the persons below, I am authorizing any employee of The Dermatology and Mohs Surgery Center of Traverse City, to release information contained in my patient records to the individuals listed below, only under the conditions listed below:

☐ Do not release any information to anyone.

☐ I authorize information to be released to (PLEASE PRINT NAMES & RELATIONSHIPS):

_____

_____

_____

Without expressed written revocation this authorization will remain in effect from date of signature.

I acknowledge that I have been offered a copy of The Dermatology and Mohs Surgery Center of Traverse City's notice of Privacy Practices explaining my rights and permitted uses and disclosures with regard to my protected health information.

Patient Signature Date: