BRUMMITTE DALE WILSON, M.D. & ASSOCIATES
DERMATOLOGY, MOHS SURGERY, AESTHETIC & LASER SURGERY
Brummitte Dale Wilson, M.D. * Cornelie M. Jones, M.D. * Peter SantaLucia, M.D.
CERTIFIED BY THE AMERICAN BOARD OF DERMATOLOGY

Personal Representative(s) Authorization

As required by the Health Insurance Portability and Accountability Act of 1996 Brummitte Dale Wilson, M.D. & Associates may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by notifying our office in writing.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the **use and disclosure** of my health information by the physicians and employees of Brummitte Dale Wilson, M.D. & Associates to my designated **Personal Representative(s)** below:

☐ my Spouse (please specify name) _____ Phone # _____

☐ my Child (please specify name) _____ Phone # _____

☐ my Parent(s) (please specify name/relationship) _____ Phone # _____

☐ my Guardian (please specify name/relationship) _____ Phone # _____

☐ other (please specify name/relationship) _____ Phone # _____

The following health information may be released to the designated Personal Representative(s) listed above:
☐ all medical & billing/financial records
☐ other _____

The release of my health information to the Personal Representative(s) named above is unlimited with the following exception(s) (if any): _____
_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by writing the practice's Privacy Officer at Brummitte Dale Wilson, M.D. & Associates, 17 Long Avenue, Suite 200, Hamburg, NY 14075. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will not expire unless I revoke it by writing the Privacy Officer as detailed above.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____
Signature Date

Hamburg Medical Park • 17 Long Avenue, Suites 200 & 201 • Hamburg, New York 14075 • Phone: (716) 648-2770 • Fax: (716) 648-1552
www.BDWilsonMD.com