

**SOCIETY HILL DERMATOLOGY**

**932 Pine Street**

**Philadelphia, PA 19107**

**215/829-6861 FAX 215/351-3926**

**Patient Authorization for Use and Disclosure  
of Protected Health Information**

By signing this authorization, I authorize Society Hill Dermatology to use and/or disclose certain protected health information (PHI) about me to:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

This authorization permits Society Hill Dermatology to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

\_\_\_\_\_  
\_\_\_\_\_

This information will be used or disclosed for the following purpose:

\_\_\_\_\_

If requested by the patient, purpose may be listed as “at the request of the individual.”

Signed by:

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Witness