WEST MICHIGAN DERMATOLOGY
Jack A. Dekkinga, MD, PC

Jack A. Dekkinga, MD Gina C. Ang, MD J. Gabriel Vasquez, MD Douglas A. Winstanley, DO
Ronald W. Reusch, PA-C Molly R. Duiven, PA-C Amber E. Kintigh, PA-C Kurt J. VanDerVeen, PA-C Sarah L. Mcintyre, PA-C

Annual Authorization Form

PROTECTED HEALTH INFORMATION AND EMERGENCY CONTACTS

There are many instances in which we are requested to share information about you, our patient, with others. This may include, but is not limited to a spouse, child, sibling or family friend. HIPPA laws prevent us from discussing any protected health information with anyone other than yourself without your written consent to do so.

Please list anyone that you authorize to have access to your protected health information in our office:

Name	Relationship	Phone #	Level of Access
			Emergency Contact: □ Yes □No Medical Information: □ Yes □No Financial Information: □ Yes □No
			Emergency Contact: □ Yes □No Medical Information: □ Yes □No Financial Information: □ Yes □No
			Emergency Contact: □ Yes □No Medical Information: □ Yes □No Financial Information: □ Yes □No
			Emergency Contact: □ Yes □No Medical Information: □ Yes □No Financial Information: □ Yes □No

***Medical Information that may be shared may include: Office Notes, Lab Results, Pathology Reports, X-Rays, Hospital notes, Nursing Home, Home Health, Hospice, Records of other Physicians offices, Records of HIV and Communicable disease testing, and Record of mental health or substance abuse treatment UNLESS otherwise stated by the patient.*

Disclosure of information will be provided by: Jack A Dekkinga MD PC
4285 Parkway Place SW, Grandville MI 49418
3124 N Wellness Dr, Suite 50, Holland, MI 49424

- This authorization will expire at the end of the calendar year in which it was signed unless otherwise specified by the patient.
- The patient has the right to terminate this request at any time – this request must be made in writing and submitted to the practice Privacy manager
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment
- We have no control over the person(s) you have listed to receive your Protected Health Information – once disclosed we have no responsibility for what the authorized person does with the information.

Patient Signature: _____Date _____

AUTHORIZATION REGARDING PAYMENT FOR SERVICES RENDERED

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or to the party who accepts or participates.

I understand the provider's charge may exceed the insurance payments including, but not limited to, copayments, co-insurances and deductibles. If greater than such payment, I will be responsible for that amount. Should my account ever become delinquent and eligible for collection, I understand an appropriate collection fee will be assessed.

Patient Signature_____ Date:_____

***All signatures valid for the duration of the calendar year in which they are signed*