Authorization to Release Information

P: 360254-5267 F: 360-254-6089

Patient Name: ____ Date of Birth: ____________

Parents' Name: ______________________________________Phone: ______________________

Dermatology Associates may

☐ OBTAIN my healthcare information from: **OR** ☐ SEND my healthcare information to:

Name or organization: ____

Address: ____

City: _______________________________________State:____________Zip: _____________

Phone: ________________________________Fax: _____________________________________

I. Information to be disclosed or received: (check all that apply):

☐ Full Medical Chart
☐ Most recent Clinic Note, Date: ____________
☐ All Clinical Notes, Last 2 years
☐ Consult / Referral Notes, Last 2 years
☐ Pathology Reports- All
☐ Laboratory Tests, Last 2 years
☐ Billing Information, last 12 Months
☐ Other: ______________________

Please Note: All of the following Sensitive Healthcare information regarding testing, diagnosis, and treatment **will be** included unless otherwise initialed.

Please Do **Not** Send (Initial all that apply):

____ HIV (AIDS virus) ____Drug and or Alcohol Abuse ____ Sexually Transmitted Disease ____ Behavioral or Mental Health

II. Description of purpose of the use and or disclosure:

☐ Transfer of Care
☐ Legal / Attorney Review
☐ Second Opinion/ Consult
☐ Personal Use
☐ Insurance Claim
☐ Other: _______________

III. My Rights

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed and that once health care information is disclosed, the person or organization that receives it may re-disclose it – privacy laws may no longer protect it.

III. This authorization ends: *(This document does not permit disclosure of health information created more than 90 or 180 days after the date it is signed.)*

☐ 90 days from the date signed below
☐ 180 days from the date signed below

Dermatology Associates
8614 E. Mill Plain Blvd, Ste 400
Vancouver, WA 98664
P: 360-254-5267
F: 360-254-6089

I authorize the transfer of my health care information **to or from** the **above address**. I understand that no charge will be made for transfer of information to another health care facility. However, if health care information is transferred to me, my family member, another person or third party such as an attorney or insurance company, the charge will be $25.00 plus $1.12 per page for the first 30 pages, and $0.84 per page after 30 pages plus applicable taxes. Payment is due before records are rendered.

____ _______________________________

Patient's signature if 16 years or older **Date** **Time**

____ _______________________________

Parent or legal guardian signature if patient is less than 16 years of age **Relationship** (parent or legal guardian)