



Authorization to Release/Obtain Information

Dermatology Associates of SW WA
Phone: 360-254-5267 Fax: 360-254-6089

Patient Name: _____ Date of Birth: _____

Parents' Name: _____ Phone: _____

Dermatology Associates may (select one)

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

Name or Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____ *****will be sent via encrypted email*****

Send to my Patient Portal account:

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

- All Dermatology Records (Including Pathology Reports) Pathology Reports - All
- Most recent Clinic Note, Date: _____ Laboratory Tests, Last 2 years
- Full Medical Chart Billing Information, last 12 Months
- Last 2 years of records only Other: _____

Please Note: 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 Second Opinion/Consult Insurance Claim
- Legal / Attorney Review Personal Use 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 for 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.
- If encrypted email is the selected format for records release, I understand and accept the potential risks of email communication. Emails are subject to file size restrictions.

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.)*

<input type="checkbox"/>	90 days from the date signed below
<input type="checkbox"/>	180 days from the date signed below

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

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 \$28.00 plus \$1.24 per page for the first 30 pages, and \$0.94 per page after 30 pages plus applicable taxes. There is a flat fee of \$6.50 for electronic records requests (sent via email/patient portal). Payment is due before records are rendered.

Patient's signature: _____ Date: _____

Parent or Legal Guardian Signature (if patient is under 16 years of age): _____

Printed Name and Relationship if Signed by Person Other Than Patient: _____