Patient Name (Last, First MI): _____

Date of Birth: _____ /_____ /_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Per ORS 192.566

THIS AUTHROIZATION MUST BE WRITTEN, COMPLETED, DATED AND SIGNED BY THE PATIENT OR THE PERSON AUTHORIZED BY LAW TO GIVE AUTHORIZATION

NOTE: INCOMPLETE FORMS WILL BE RETURNED TO THE REQUESTING INDIVUDUAL/ENTITY FOR COMPLETION

RELEASE RECORDS TO:
THE CLINIC FOR DERMATOLOGY & WELLNESS, LLC
2924 Siskiyou Blvd. Suite 200
Medford, OR 97504
Phone: (541)-200-2777 Fax: (541) 214-2575
Provider:_____

RECORDS FROM:
Provider/Clinic:_____
Address:_____
_____
City:_____ State:_____ Zip:_____
Phone: _____ Fax:_____

I authorize the use and disclosure of a copy of the specific health information described below regarding the patient indicated above, consisting of:

_____ Clinician office progress notes
_____ Diagnostic imaging reports
_____ Pathology reports
_____ Laboratory reports

For Dates of service:

_____ All dates of service *OR* From: _____ To: _____

to the named recipient (or recipients) at the address indicated above, for the purpose of (check all that apply):

_____: Continuity of care _____: Transferring Care _____: Other_____
_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Genetic testing information
_____ Mental health information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to:

The Clinic for Dermatology & Wellness, LLC
ATTN: Medical Records Department
2924 Siskiyou Blvd. Ste. 200
Medford, OR 97504.

I have read this authorization and I understand it. Unless revoked, this authorization expires one calendar year after the date I signed this form, as indicated below.

Signature of patient or patient representative: _____ **Date:**_____
Name of patient's representative (if applicable): _____
Description of patient's representative's authority (if applicable): _____