MEDICAL RECORDS RELEASE FORM

Authorization to Use and Disclose Protected Health Information

Patient Name: ___________________________ Date of Birth: ____________________ Phone: _______________

I REQUEST AND AUTHORIZE:
Organization/Person ____ Phone: _______________

Organization Address____ Fax: _______________

TO RELEASE RECORDS TO:
Organization/Person ____ Phone: _______________

Organization Address____ Fax: _______________

The information to be disclosed (if such records exist):

___ Billing Statement(s)

___ Clinical Record(s)

___ Cosmetic Record(s)

___ Diagnostic Imaging Report(s)

___ Laboratory Report(s)

___ Pathology Report(s)

___ Other: ____

This authorization DOES NOT apply to records related to HIV/AIDS, metal health, genetic testing, or drug/alcohol diagnosis. A separate, signed authorization form is required for those records.

I understand that I may revoke my authorization at any time by making such a request in writing to Deschutes Dermatology Center. This authorization shall expire automatically one year from the date of my signature, unless requested to end at an earlier date: _______________. I also understand that once released, my protected health information may be subject to redisclosure.

Patient Signature: ____ Date: _________________________________
Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to patient (if other that self): ____
Adapted from ORS 192.518 to 192.526

Printed Patient Name: ______________________________________

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