

**Center for Dermatology and Laser Surgery**

St. Vincent Location: 9135 SW Barnes Rd. Ste. 875 Portland, OR 97225  
Hillsboro Location: 5920 NE Ray Cir. Ste 200 Hillsboro, OR 97124  
P: 503-297-3440 F: 503-297-4584 Web: Centerdermlaser.com

**Authorization to Release Healthcare Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Previous Name (if any): \_\_\_\_\_ Phone: \_\_\_\_\_  
Are you authorizing the release of your own records? Yes  No   
If not, what is your name and relationship to the patient?  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Information to be released by:**

Organization: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**Information to be released to:**

Organization: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**Information to be released:** please check all that apply

Health Care Information in my medical record relating to treatment/condition of:

For the date range: \_\_\_\_\_

Complete Dermatology Chart Record-This should only be checked if your provider has asked for it. **This is limited to the two (2) most current years of information including; laboratory, X-ray and Pathology Reports, not include billing information. Please see above choice if records are older than two (2) years to give specific dates and treatment/condition.**

**Billing Records:** please check all that apply

All Records (This is limited to the two (2) most current years of information)

For the treatment/condition OR dates of: \_\_\_\_\_

**Requests for information older than two (2) years will be subject to copying charges, \$1.04/page for the first thirty (30) pages and \$0.79/page thereafter.**

**Uses and Disclosures requiring specific authorization:** Unless specifically **EXCLUDED** this authorization of Health Information may include documentation regarding the referral, diagnosis and treatment information relating to:

- HIV/AIDS  Sexually transmitted disease  Mental Health or Illness  Drugs and/or Alcohol abuse
- Reproductive Care (Minors only)

**Purpose for which disclosure is being made:**

- Concurrent Care  Transfer of Care  Insurance  Personal Use

**My Rights:**

*I understand that I have a right to revoke this authorization at any time if I revoke this authorization, I must do so in writing and present my written revocation to Center for Dermatology and Laser Surgery. If information has already been released based on this release, the revocation will not apply to that information. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that when the information is disclosed, federal privacy laws or regulations may not protect the information and the recipient may re-disclose it.*

*I authorize release of my medical records, as described above. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, however I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.*

\_\_\_\_\_  
**Signature of patient or legal authorized representative**

\_\_\_\_\_  
**Date**

**Expiration:** 30 days from the date signed.