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 the following charges: Pages 1 – 10 : $30.00 Flat Fee, Pages 11 – 50 : $0.50 per page, Pages 51+ : $0.25 per page, Postage : Actual cost of mailing

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

DateExpiration: 30 days from the date signed.