SPOKANE DERMATOLOGY CLINIC

324 S Sherman St, Spokane, WA 99202

TELEPHONE: (509) 624-1184 OR (800) 998-DERM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patients Name: _____
Last First MI

Date of birth: _____ SS#: _____ Phone #: _____

Send Records TO/FROM (Circle one): Spokane Dermatology Clinic, PS
ATTN: _____
324 S Sherman St
Spokane, WA 99202
Fax: (509) 343-3723

Send Records TO/FROM (Circle one): Name: _____

Fax #: _____

Phone# _____

Address: _____

_____

Records to be released:

( ) All ( ) Medical Record Notes ( ) Lab ( ) Pathology ( ) Other: _____

I understand that my express consent is required to release any health care information relating to my health, testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted disease, psychiatric disorders/mental health, and/or alcohol abuse. You are specifically authorized to release all health care information relating to such testing, diagnosis, and/or treatment of the aforementioned conditions, unless otherwise specified. Washington State Law, RCS 70.24 ET SEQ.

I hereby release Spokane Dermatology Clinic, PS and its staff from all legal responsibility that may arise from the act hereby authorized.

_____ _____ _____
Patient Signature Printed Patient Name Date

If patient is a minor:

_____ _____ _____
Parent/Legal Guardian Signature Printed Name Relationship to Patient

Note: When a patient has reached his or her 18th birthday, only the patient may authorize disclosure of medical records.

This authorization must be dated within 90 days of the request for information and can be revoked at any time providing that the information has not yet been released. No information for medical treatment received after the date of this authorization will be released.

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Office Use Only:		
Mailed:___/___/___ by:_____	Faxed: ___/___/___ by:_____	Copy to Patient: ___/___/___ by:_____