NORTH SOUND
DERMATOLOGY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

_____ _____
PRINTED NAME OF PATIENT **PREVIOUS NAME, IF APPLICABLE**

_____ _____
DATE OF BIRTH **DAYTIME PHONE NUMBER**

SEND INFORMATION *TO*:

Provider/Organization: _____

Address: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED *FROM*:

Provider/Organization: _____

Address: _____

Phone: _____ Fax: _____

PURPOSE OF DISCLOSURE:

☐ Transfer of care ☐ Continuity of care ☐ Specialist ☐ Personal ☐ Legal ☐ Insurance

INFORMATION TO BE DISCLOSED:

☐ Medical records within the last 2 years

☐ All medical records (all medical records per *Washington State Records Retention Guidelines)*

☐ Other (indicate specific procedures and dates of service) _____

I understand that the information in my medical record may include information relating to testing, diagnosis, or treatment for: HIV/AIDS virus, mental health/psychiatric disorders, sexually transmitted diseases, and drug and alcohol abuse/treatment. I authorize the release or disclosure of this type of information.

MINORS AGE 13-17:

A minor patient's consent is required in order to release information concerning care for: 1) conditions relating to the minor's sexuality including, but not limited to: contraception, pregnancy and sexually transmitted diseases (age 14 and above; 2) alcohol and/or drug abuse (age 13 and above); and 3) mental conditions (age 13 and above).

I understand that once North Sound Dermatology discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws. I also understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). My authorization is required to take part in a research study and to receive health care when the purpose is to create health information for a third party. You have the right to revoke or cancel this authorization, in writing, at any time (see reverse).

This authorization expires _____ (date or event). Authorization will expire in 90 days if not otherwise specified.

_____ _____
DATE **PATIENT SIGNATURE**

_____ _____
DATE **PARENT OR LEGAL GUARDIAN**

RELATIONSHIP TO PATIENT, IF OTHER THAN PATIENT _____

CANCELLATION NOTICE

According to the Uniform Health Information Act for the State of Washington, records shall be released within fifteen days after receipt of a signed, dated release form. Since records are usually handled within 2 – 3 days after receipt, North Sound Dermatology will not be held responsible for any release of medical information accomplished before receipt of a written notice of cancellation. Revocation takes place from the date of receipt of the written request.

Instructions for Canceling a Request:

1. You must provide a written request asking for revocation/cancellation of the original record release.
2. We need to have your complete name, date-of-birth, telephone number (home/work) and the name of the person/agency that you authorized to receive the medical information.
3. After receipt of the notice, telephone confirmation will acknowledge your withdrawal of authorization.
4. If the release has been accomplished, you will be notified. The release will be revoked for any further disclosure.
5. If you have any questions concerning the cancellation process, call 425-385-2009.