AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

I authorize _____ to release a copy of the medical information for

Patient: _____ DOB: _____

To: _____

Address: _____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ Medical records needed for continuity of care

_____ Laboratory reports

_____ Pathology reports

_____ Emergency and urgency care records

_____ Billing statements

_____ Other

_____ Please send the entire medical record (all information) to the above named recipient. **(The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record)**

_____ *HIV/AIDS related records

_____ ***Mental health information

_____ ***Genetic testing information
(*** These types of records MUST BE INITIALED to be included in other documents)**

_____ **Drug/alcohol diagnosis, treatment, or referral information as follows
(Federal Regulation, 42CFR Part 2, requires a description of how much and what kind of information is to be disclosed)**

_____ This authorization is limited to the following treatment: _____

_____ This authorization is limited to the following time period: _____

_____ This authorization is limited to a worker's compensation claim for injuries of _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Signature of patient) (Date)

_____ _____
(Signature of person authorized by law) (Date)

DERMATOLOGY ASSOCIATES 10215 SW Hall Blvd Tigard, OR 97223

503-245-2415 FAX 503-244-5963