Patient Authorization to Disclose Health Information

Patient Name	Date of Birth	Telephone #

I authorize:

Fair Winds Dermatology

2430 NW Professional Dr, Corvallis, OR 97330

Ph: 541-452-0180 Fax: 541-427-4435

Provide Information To:

____

Facility/Person *Phone #* *Fax #*

____

Street Address *City/State/Zip*

The information will be used on my behalf for the following purpose(s): ____

____

Information to Be Disclosed:

- ❑ Entire Chart
- ❑ History & Physical
- ❑ Medications / Therapy
- ❑ Lab / Pathology / ECG Reports
- ❑ Billing Ledger
- ❑ All Clinician(s) Chart Notes
- ❑ Immunizations
- ❑ Problem List
- ❑ Operative Reports
- ❑ Other Records as Specified: ______________________
- ❑ **Specific Dates of Treatment:** ______________________

- I understand that this authorization will automatically expire in 180 days from the date of my signature or on (date): ______________________
- Records are limited to the last two (2) years of information and excludes other protected records.
- I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Fair Winds Dermatology. I understand that the revocation will not apply to information that has already been disclosed in response to and in reliance on this authorization. I understand that 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 once the information is disclosed pursuant to this authorization it may be subject to re-disclosure by the recipient and the information may not be protected by federal privacy regulations. However, I also understand that federal or state law may restrict re-disclosure of HIV / AIDS related information, psychotherapy / mental health program notes, genetic testing information, and drug / alcohol addiction program records.
- I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
- I understand that I will be given a copy of this authorization form after signing.

_______________________________ _______________________________

Signature of patient *Date*

_______________________________ _______________________________

Signature of person authorized by law to sign for patient *Relationship to patient*