

Patient Authorization to Disclose Health Information

Patient Name

Date of Birth

Telephone #

I authorize:

Provide Information To:

Facility/Person

Phone #

Fax #

Street Address

City/State/Zip

Fair Winds Dermatology

2430 NW Professional Dr.

Corvallis, OR 97330

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

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
- Imaging Reports
- 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): _____
- 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, and 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