



AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

PATIENT INFORMATION:

Name: _____ Social Security: _____
Former Name (if any): _____ Birth date: _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize (Name of Organization): _____

To release the following medical information contained in the patient's medical record.

Address (if other than Island Dermatology):

Street

City State Zip

INFORMATION TO BE RELEASED TO: _____ If other than Island Dermatology

_____ Island Dermatology, PLLC
8435 SE 68th St., #118
Mercer Island WA 98040

Street

City State Zip

TYPE OF INFORMATION TO BE RELEASED:

_____ Summary of medical history/ treatment From: _____ Dates of Treatment To: _____
_____ Laboratory/ Diagnostic tests From: _____ To: _____
_____ Pathology reports From: _____ To: _____
_____ Other records: _____

I understand that I am not required to sign this authorization in order to get the health care benefit except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that I have the right to revoke this authorization at any time except to the extent that Island Dermatology PLLC has already acted in reliance on this authorization. To revoke this authorization, I understand that I must do so by written request to: Island Dermatology 8435 Se 68th St Suite 118, Mercer Island, WA 98040. The authorization will stop on the date the request to revoke the authorization is received.

Once Island Dermatology has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information related to health care provided to me more than ninety days after the date of this authorization. This prohibition does not extend to insurance companies.

I understand I may revoke this consent at any time. This consent expires on _____ or ninety(90) days.

_____/_____/_____
Date Signature of Patient or Legally Responsible Party Relationship to Patient if not Patient