Island Dermatology, PLLC
8435 SE 68th ST, Suite #118
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AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

PATIENT INFORMATION:

Name: ____ DOB: ____________________

Former Name (if any): ____

Phone Number: ____

INFORMATION TO BE RELEASED **BY**: Request must have completed address or fax number	INFORMATION TO BE RELEASED **TO**: Request must have completed address or fax number
Organization: ______________________ Address: ______________________ ______________________ Phone: ( ) ______________________ Fax: ( ) ______________________	Organization: ______________________ Address: ______________________ ______________________ Phone: ( ) ______________________ Fax: ( ) ______________________

TYPE OF INFORMATION TO BE RELEASED:

- ☐ Complete Medical Record Abstract (includes last three years of chart notes, lab/diagnostic tests, and pathology reports)
- ☐ Most recent Chart Note(s) Dates: ____
- ☐ Laboratory/Diagnostic Tests Dates and/or body location: ______________________________
- ☐ Pathology Reports Dates and/or body location: ______________________________
- ☐ Other: ____

My signature below indicates that I hereby agree to and authorize the release of patient heath information to the above named person or organization. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. I understand that I have the right to revoke this authorization by written request at any time except to the extent that Island Dermatology PLLC has already acted in reliance on this authorization. I understand that I am not required to sign this authorization in order to get health care benefits (treatment, payment, or eligibility for benefits) unless I receive the health care with the sole purpose of creating health care information for a third party. Once Island Dermatology has disclosed health information, the recipient may re-disclose in some situations. Privacy laws may no longer protect the information. This consent expires in 90 days. A new authorization will need to be provided after 90 days for the above listed organization or as authorization to release health information to any other organization.

Patient/Guardian Signature: ____ **Date:** ____________________

Print Name: ____ **Relationship to patient if not patient:**____________________