Northwest Dermatology Medical Record Release

Patient name: ____________________________________ Date of birth:_____________________

Previous / Maiden name: ___________________________________

I. My Authorization

You may disclose or obtain the following health care information (check all that apply):

☐ All health care information in my medical record
☐ Health care information in my medical record relating to the following treatment or condition:
____
☐ Health care information in my medical record for the date(s): ____________________________
☐ Other (e.g., X rays, bills), specify date(s):____
☐ **All**

You may disclose or obtain health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ **All**
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

You may disclose / obtain *(circle one)* **this health care information to / from** *(circle one)***:**

Name (or title):____

Organization: ____

Address: ______________________________ City: ____________ State:_____ Zip: __________

Phone Number:___________________________ Fax Number:_______________________________

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

☐ in 90 days from the date signed
☐ when the following event / date occurs: ____
(no longer than 90 days from date signed)

II. My Rights

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:
- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.
I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Northwest Dermatology based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
- Fill out a revocation form. A form is available from Northwest Dermatology. Or
- Write a letter to Northwest Dermatology.
- Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____ ______________________________
Patient or legally authorized individual signature Date Time

____ ______________________________
Printed name if signed on behalf of the patient Relationship

Incomplete Forms Will Not Be Processed

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