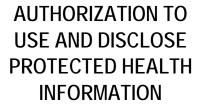
## Phoebe Rich Dermatology

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Last	Name:	First Name:	Middle:
Oth	er Names Used:		Date of Birth:
I au	uthorize Phoebe Rich Dermatolo	ogy to send the followin	g records:
□ E	ntire Health Record	□ La	b Reports
□ M	ost Recent Chart Notes	□ X-	ray Reports/Films
$\Box$ D	ischarge Summaries	□ EK	G, EEG, EMG
□ Pa	athology Reports	□ Ot	her:
□ Ir	mmunization Records		
*Ву	initialing the spaces below, I sp	pecifically authorize the	release of the following health information:
Ment	tal Health Drugs or Alcoho	ol HIV/AIDS/Oth	er Infections Disease Genetic Testing
Plea	ase select your preferred metho	od of record transfer:	
	will pick up copies of my records	□ Ma	il copies of my records to the individual noted below
□ Fa	ax my records to (see below)	□ Em	nail encrypted photographs to:
		Please Send Reco	rds To:
Nan	ne of Provider:		
Add	ress:		
Pho	ne:		
Fax:	:		
I u	nderstand:		
	THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.		
	I do not have to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.		
	I may revoke this authorization in writing at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to <a href="the address provided at the top of this">the address provided at the top of this</a> authorization stating that you are revoking this authorization.		
	*Additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information indicated above. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information.		
-	I HAVE READ THIS AUTHORIZATIO	N AND I UNDERSTAND IT.	
-	UNLESS REVOKED, THIS AUTHORIZ	ZATION EXPIRES:	(SPECIFY DATE OR EVENT)

By typing your name above, you indicate that you have read, understand, and agree to this document.