Phoebe Rich Dermatology **Fax: (503) 223-9561**
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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Last Name:_____ **First Name:** _____ **Middle:** _____

Other Names Used: _____ **Date of Birth:** _____

I authorize Phoebe Rich Dermatology to send the following records:

- ☐ **Entire Health Record**
- ☐ Most Recent Chart Notes
- ☐ Discharge Summaries
- ☐ Pathology Reports
- ☐ Immunization Records
- ☐ Lab Reports
- ☐ X-ray Reports/Films
- ☐ EKG, EEG, EMG
- ☐ Other: _____

***By *initialing* the spaces below, I specifically authorize the release of the following health information:**

Mental Health _____ Drugs or Alcohol _____ HIV/AIDS/Other Infections Disease _____ Genetic Testing _____

Please select your preferred method of record transfer:

- ☐ I will pick up copies of my records
- ☐ Fax my records to (see below)
- ☐ Mail copies of my records to the individual noted below
- ☐ Email encrypted photographs to:_____

Please Send Records To:
Name of Provider:
Address:
Phone:
Fax:

I understand:

- **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 ***the address provided at the top of this 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 AUTHORIZATION AND I UNDERSTAND IT.**
- **UNLESS REVOKED, THIS AUTHORIZATION EXPIRES:** _____
(SPECIFY DATE OR EVENT)

_____ _____ _____
Signature of Patient, Parent, or Legal Authorized Representative** Relationship to Patient Date
By typing your name above, you indicate that you have read, understand, and agree to this document.