SPECTRUM
DERMATOLOGY OF SEATTLE

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth _____

Phone: _____ Last Four of Social Security: _____

INFORMATION TO BE RELEASED FROM:

_____
Name of Organization

_____
Address

_____
City/State/Zip Code

_____
Phone / Fax Number

INFORMATION TO BE RELEASED TO:

Spectrum Dermatology of Seattle, PLLC
Name of Organization

805 Madison Street, Suite 701
Address

Seattle, WA, 98104
City/State/Zip Code

p 206.707.9299 f 206.432.4552
Phone / Fax Number

Type of Records to be Released: (Please check all that apply)
___ Last two years of Chart Records___ Specific: Chart Notes: _____
___ Labs/Reports: ___Other: _____

Certain sensitive health information requires specific written consent. Please initial the appropriate request:
___ Drug and/or Alcohol Abuse
___ Mental Health
___ Sexually Transmitted Diseases (includes AIDS/HIV)

For The Purpose Of: (Please check all that apply)
___ Concurrent/Referral Care ___ Transfer of Care ___ At My Request Other: _____

My Rights:

- I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
- I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment).
- I understand once Spectrum Dermatology of Seattle has released my health care information to the above named entity, the person or organization that receives it may re-disclose the information and that it may no longer be protected by privacy laws.
- I understand if I request my records for personal use, and the request exceeds 10 pages, I may be charged by Spectrum Dermatology of Seattle.

I have read the above Authorization to Release Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature: _____ Date: _____

POA/ Patient Guardian Signature: _____ Date: _____

Please attach a copy of legal documents if you are the legal guardian or holder of Power of Attorney or indicate they are on file.