



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.