805 MADISON ST, SUITE 703
SEATTLE, WA 98104
(206) 456 4464 Ph
(206) 420 6851 Fax

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**:

_____
Name of Organization

_____
Address

_____
City/State/Zip Code

_____
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 require 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 Young Dermatology 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 Young Dermatology.

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.