

Authorization to Release Healthcare Information

I hereby request and authorize	Patient Name:		Date of Birth:
Name/Facility: Cascade Dermatology PO Box 5679 Address: Eugene, OR 97405 Fax: 541-345-5254 City: State: Zip: I would like the following information released to the above stated entity: Chart notes pertaining to dermatology Chart notes pertaining to specific diagnosis and dates: Pathology Reports	I hereby request and authorize _		
Address:	to release healthcare information	n of the above named patient t	o:
Address:	Name/Facility:		33
City: State: Zip: I would like the following information released to the above stated entity: Chart notes pertaining to dermatology Chart notes pertaining to specific diagnosis and dates: Pathology Reports	Address:		Eugene, OR 97405
□ Chart notes pertaining to dermatology □ Chart notes pertaining to specific diagnosis and dates: □ Pathology Reports □ Lab Reports □ Entire Medical Record* * Notice: If sending facility is intending to fax more than 15 pages, please mail records to the address noted below. Cascade Dermatology does not provide copies of records received from another physician or facility. Please request these records directly from the original healthcare provider. Purpose for which this information is being released: □ Continued Medical Care □ Legal □ Transfer to another provider □ Insurance □ Personal □ Consultation with specialist □ Other: □ Insurance □ Personal □ Consultation with specialist □ Other: □ Insurance □ I	City: Stat	te: Zip:	FAX. 541-545-5254
□ Chart notes pertaining to specific diagnosis and dates: □ Pathology Reports □ Lab Reports □ Entire Medical Record* * Notice: If sending facility is intending to fax more than 15 pages, please mail records to the address noted below. Cascade Dermatology does not provide copies of records received from another physician or facility. Please request these records directly from the original healthcare provider. Purpose for which this information is being released: □ Continued Medical Care □ Legal □ Transfer to another provider □ Insurance □ Personal □ Consultation with specialist □ Other: □ Insurance □ Insuranc	I would like the following informa	ation released to the above sta	ated entity:
□ Pathology Reports □ Lab Reports □ Entire Medical Record* * Notice: If sending facility is intending to fax more than 15 pages, please mail records to the address noted below. Cascade Dermatology does not provide copies of records received from another physician or facility. Please request these records directly from the original healthcare provider. Purpose for which this information is being released: □ Continued Medical Care □ Legal □ Transfer to another provider □ Insurance □ Personal □ Consultation with specialist □ Other: □ Insurance □ Insurance □ Personal □ Consultation with specialist □ Other: □ Insurance □ Insurance □ Insurance □ Insurance □ Insurance □ Insurance □ Information released is confidential and must be used for the purpose that it was requested for and once the information has been disclosed may not be protected by federal and state confidentially laws. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. You may revoke this authorization in writing at any time. If you revoke your 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 Cascade Dermatology, 992 Country Club Rd #1, Eugene OR 97401 and state that you are revoking this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or	☐ Chart notes pertaining to der	matology	
* Notice: If sending facility is intending to fax more than 15 pages, please mail records to the address noted below. Cascade Dermatology does not provide copies of records received from another physician or facility. Please request these records directly from the original healthcare provider. Purpose for which this information is being released: Continued Medical Care Legal Transfer to another provider Insurance Personal Consultation with specialist Other: Lunderstand that: The information released is confidential and must be used for the purpose that it was requested for and once the information has been disclosed may not be protected by federal and state confidentiality laws. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. You may revoke this authorization in writing at any time. If you revoke your 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 Cascade Dermatology, 992 Country Club Rd #1, Eugene OR 97401 and state that you are revoking this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or	☐ Chart notes pertaining to spe	ecific diagnosis and dates:	
Dermatology does not provide copies of records received from another physician or facility. Please request these records directly from the original healthcare provider. Purpose for which this information is being released: Continued Medical Care Legal Transfer to another provider Insurance Personal Consultation with specialist Other: I understand that: The information released is confidential and must be used for the purpose that it was requested for and once the information has been disclosed may not be protected by federal and state confidentiality laws. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. You may revoke this authorization in writing at any time. If you revoke your 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 Cascade Dermatology, 992 Country Club Rd #1, Eugene OR 97401 and state that you are revoking this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or	□ Pathology Reports	☐ Lab Reports ☐	Entire Medical Record*
□ Continued Medical Care □ Legal □ Transfer to another provider □ Insurance □ Personal □ Consultation with specialist □ Other: □ Understand that: The information released is confidential and must be used for the purpose that it was requested for and once the information has been disclosed may not be protected by federal and state confidentiality laws. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. You may revoke this authorization in writing at any time. If you revoke your 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 Cascade Dermatology, 992 Country Club Rd #1, Eugene OR 97401 and state that you are revoking this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or	Dermatology does not provide copies of rec		
□ Personal □ Consultation with specialist □ Other:	Purpose for which this information	on is being released:	
The information released is confidential and must be used for the purpose that it was requested for and once the information has been disclosed may not be protected by federal and state confidentiality laws. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. You may revoke this authorization in writing at any time. If you revoke your 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 Cascade Dermatology, 992 Country Club Rd #1, Eugene OR 97401 and state that you are revoking this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or		_	
	The information released is confidential and disclosed may not be protected by federal at the date of signing or shall remain in effect authorization in writing at any time. If you i disclosed for the purposes described in this reliance on the authorization or the authorization, please send a written statem are revoking this authorization. Refusal to s	and state confidentiality laws. Unless rever for the period reasonably needed to confidence your authorization, the information written authorization. The only exception zation was obtained as a condition of obtained to Cascade Dermatology, 992 Counting	roked earlier, this consent will expire 180 days from inplete the request. You may revoke this on described above may no longer be used or in is when a covered entity has taken action in taining insurance coverage. To revoke this by Club Rd #1, Eugene OR 97401 and state that you
Sign Here: Patient/Parent/Legal Agent Date		t/Parent/Legal Agent	Date