CASCADE DERMATOLOGY
aesthetics

Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

I hereby request and authorize _____

to release healthcare information of the above named patient to:

Name/Facility: _____

Address: _____

City: _____ State: ____ Zip: _____

❑ Cascade Dermatology
PO Box 5679
Eugene, OR 97405
Fax: 541-345-5254

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 ❑ 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: _____

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, PO Box 5679, Eugene OR 97405 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 reimbursement for services.

Sign Here: _____
Patient/Parent/Legal Agent Date