North Idaho DERMATOLOGY

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

*** Some requests may be subject to a $10.00 charge with 10 cents per page for copying complete records***

Patient's Name: _____
(Last) (First) (Middle)

Birth Date: _____ SSN#: _____ Phone: _____

Release From: _____

_____

_____

Phone: _____

Fax: _____

Release To: _____

_____

_____

Phone: _____

Fax: _____

Please check on of the following options:

( ) Patient will pick up and hand carry records
( ) North Idaho Dermatology will mail or fax records to the individuals or organization above
( ) The individual or organization above will mail or fax records to North Idaho Dermatology

Information to be released:

( ) All Medical Records
( ) All Dermatological Records
( ) Pathology/Laboratory
( ) Other: _____

Exceptions (If Any): See disclosure statement below

_____

_____

For the purpose of:

( ) Transfer of Medical Care ( ) Billing Purposes ( ) Legal Matters ( ) Personal ( ) Continued Care

I understand that authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I authorize the use and disclosure of my entire patient file including any information that I might consider sensitive such as mental health, sexually transmitted diseases, alcohol/drug abuse treatment, HIV/AIDS related treatment, etc. If there are certain parts of my medical record I do not want disclosed, I have written those exceptions on this form in the space above. I hereby release the Supplier and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be disclosed by the recipient.

REVOCATION: I understand that I may revoke this authorization at any time by notifying the Health Information Management Department at North Idaho Dermatology in writing and by completing the REVOCATION OF AUTHORIZATION form. I understand that the revocation will not apply to information that has already been released in response to this authorization.

EXPIRATION: This authorization will expire in 6 months from date of signature.

Please allow 7-10 business days for processing.

Printed Name of Patient or Guardian: _____

Signature of Patient or Guardian: _____ Date: _____

Signature of Person Releasing: _____ Date: _____