LAKE OSWEGO DERMATOLOGY GROUP
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Authorization to release medical information from Lake Oswego Dermatology Group

Patient's Name: ____ D.O.B.: _______________

Address: ____ Phone Number: _________________

I authorize my medical information to be sent to: ____
(Health care provider/other party)

Address: ____ Fax Number:_________________

This information will be used on my behalf for the following purpose(s): ___________________________

I specifically authorize the release of the following medical records, if such records exist:

___ General medical records – excluding protected records. Copies of medical records will be limited to five years of information including clinician office notes, laboratory and pathology reports.

-OR-

___ Clinician chart notes
___ Laboratory reports
___ Pathology reports

I understand that certain information cannot be released without specific authorization. By initialing I authorize the release of the following protected or sensitive information.

_____ Sexually transmitted diseases
(initial)

_____ Aids/HIV test results
(initial)

By signing this form, you are authorizing the use or disclosure of your protected health information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

__________________________________ __________________________________ ___________
(Signature) (Relationship to patient) (Date)

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