Authorization to Release Medical Information

Please Release my records:

TO: _____ FROM:_____

Central Oregon Dermatology
388 SW Bluff Drive
Bend, OR 97701
Telephone (541)678-0020 Fax (541)323-2174

FROM:_____ TO:_____

_____

_____

_____

MAIL _____ FAX: ( )_____
Fax number please

Only Records pertaining to Dermatology:_____

Other: _____

This authorization expires on _____ (only good for 1 year)

Yes____ No_____ I authorize the release of my Sexually Transmitted Disease (STD) results, including HIV/AIDS testing, whether negative or positive to the persons listed above.

Yes____No_____ I authorize the release of any records regarding drug, alcohol or mental health treatments to the persons listed above.

Patient Name: _____ Date of Birth_____

Address: _____ _____
City State Zip Telephone Number

_____ _____
Patient Signature Date Signed

I fully understand that the entity that receives this information is not required to comply with Federal Privacy information and my information may no longer be protected. I may REVOKE this authorization at any time. To Revoke this authorization, I must notify Central Oregon Dermatology PC in writing. I understand that I do not have to sign this authorization and that my refusal to sign in no way affects my treatment from Central Oregon Dermatology PC.