GOODSKIN DERMATOLOGY

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AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	Telephone:
Address:	Birth Date:
City: State: Zip:	Other name used:

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

Name of the provider to release information			**Name of the person/provider to receive information**		
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:	Fax:		Phone:	Fax:	

Purpose of Release: _____

If such information exists, I authorize the disclosure of:
□ The entire medical record. (The 2 most recent years of pertinent records will be released.)
□ The following specific documents, dates of service, and/or information about the following injury/illness/disease:

_____

The following items must be initialed to be released:
_____ HIV-positive test results and HIV diagnosis
_____ Mental health information and/or records (Oregon only)
_____ Genetic testing information and/or records (Oregon only)
_____ Other sexually transmitted diseases (Washington only)
_____ Drug/alcohol diagnosis, treatment or referral information.

Per Federal regulations, describe how much and what kind of information is to be disclosed:

_____

Federal or state law may restrict re-disclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information. The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so. The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.
I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization.
Unless revoked earlier, this authorization will expire on the earlier of 1 year from the date of signing.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name (If other than patient, proof of authority is required.) Relationship to Patient

Revised 03/09/2020