

**PACIFIC NORTHWEST DERMATOLOGY
RELEASE OF INFORMATION
AUTHORIZATION / REQUISITION FORM**

Section A: This section to be completed by the patient

Patient Name:		Date of Birth:			
Address:		Phone Number:			
		Date of Birth:			
RELEASING Facility	Facility Name:	Pacific Northwest Dermatology			
	Address:	7502 Lakewood Dr. W, Suite A			
	City/State/Zip:	Lakewood, WA 98499			
	Phone #:	253-572-2842			
REQUESTING Facility or Individual	Requestor Name:				
	Address:				
	City/State/Zip:				
	Phone/Fax #:				
Date(s) of Service:					
List specific description of information to be released:	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Imaging Reports	<input type="checkbox"/> Orders	<input checked="" type="checkbox"/> All records
	<input type="checkbox"/> Billing Records	<input type="checkbox"/> EKG's	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Other _____
	<input type="checkbox"/> UB92	<input type="checkbox"/> Emergency	<input type="checkbox"/> Medication	<input type="checkbox"/> Pathology	<input type="checkbox"/> _____
	<input type="checkbox"/> Itemized Bills	<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Nursing	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> _____
	<input type="checkbox"/> Consultation	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Surgery/Procedure	<input type="checkbox"/> Accounting of Dis.	<input type="checkbox"/> _____

Section B: This section to be used for providers own disclosure purposes:

Purpose of Disclosure: **Dermatology Care**

Will Physician receive financial or "in-kind" compensation for the use/disclosure of information described above?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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Section C: Must be completed by the patient for all aauthorizations

The patient or the patient's representative must read and complete the information in this section:

1. I understand that the persons herby authorized to use/disclose information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on ____/____/____.
3. I understand that I may revoke this authorization at any time by notifying the Physician's office in writing, except to the extent the Physicians office has already taken action in reliance on the previous authorization.
4. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
5. I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.
6. I understand that I may refuse to sign this authorization and in doing so, understand the refusal to sign this authorization will not affect my treatment.

I herby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that this authorization also applies to records about me containing information about HIV, AIDS, venereal disease, or mental disorders. In accordance with federal regulation 42 CFR part2: I also understand that the release of any and all alcohol and/or drug abuse treatment that such information cannot be release without my specific authorization, except in special circumstances. Therapists notes related to mental disorders will also require a specific authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulation, the release information may no longer be protected by federal privacy regulations.

		FOR OFFICE USE ONLY	
(Signature of Patient or Patient's representative)	(Date)	Patient Acct #:	
		Staff Initials:	
(If patient representative, please print name above)			