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:				
	Address:				
	City/State/Zip:				
	Phone #:				
REQUESTING Facility or Individual	Requestor Name:	**Pacific Northwest Dermatology**			
	Address:	**1901 UNION AVE, SUITE 3003**			
	City/State/Zip:	**TACOMA, WA 98405**			
	Phone/Fax #:	**Ph: 253-572-2842 Fax: 253-572-2856**			
Date(s) of Service:					
List specific description of information to be released:	❑Anesthesia ❑ Billing Records ❑UB92 ❑Itemized Bills ❑Consultation	❑Discharge Summary ❑EKG's ❑Emergency ❑Face Sheet ❑History & Physical	❑Imaging Reports ❑Laboratory ❑Medication ❑Nursing ❑Surgery/Procedure	❑Orders ❑Outpatient ❑Pathology ❑Progress Notes ❑Accounting of Dis.	☒All records ❑Other _____ ❑_____ ❑_____ ❑_____

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?	❑Yes	X No

Section C: *Must be completed by the patient for all aouthorizations*

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 #:	
(If patient representative, please print name above)		Staff Initials:	