OLYMPIC DERMATOLOGY
Medical & Cosmetic Excellence

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

424 Lilly Road NE, Olympia, WA 98506 | Phone: (360) 459-1700 | Fax: (360) 459-0537 | www.olympicdermatology.com

Patient Name: _____ Date of Birth: _____
Previous Name (if any): _____ Phone: _____

Are you authorizing the release of your own records? ❒ Yes ❒ No
If not, what is your name and relationship to the patient? _____

INFORMATION TO BE RELEASED FROM:

Organization: _____
Name: _____
Address: _____
Phone: _____
Fax: _____

INFORMATION TO BE RELEASED TO:

Organization: _____
Name: _____
Address: _____
Phone: _____
Fax: _____

Information to be released (please check all that apply):

- ❒ All healthcare information in my medical record
- ❒ Healthcare information in medical record relating to the following treatment or condition: _____
- ❒ Healthcare information in my medical record for the dates: _____
- ❒ Other (ex: x-rays, bills) – specify date(s): _____

Format: ❒ Secure Fax ❒ Patient Portal ❒ CD (add'l $3.00) ❒ Paper Mailed ❒ Paper Pickup

Fees: Our office charges $1.17 per page for the first 30 pages of printed copies of medical records, and $0.88 per page for each additional page. RCW 70.02.010(37) Please allow (15) fifteen business days to process the request. RCW 70.02.080.

Uses and Disclosures requiring specific authorization:

Unless specifically EXCLUDED this authorization of Health Information may include documentation regarding the referral, diagnosis and treatment information relating to: ❒ HIV/AIDS ❒ Sexually Transmitted diseases ❒ Mental Health or Illness ❒ Drugs and/or alcohol abuse ❒ Reproductive Care

Purpose for which disclose is being made: ❒ Continuity of Care ❒ Transfer of Care ❒ Insurance ❒ Personal Use ❒ Marketing ❒ Other: _____

My Rights: *I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits.) However, I do have to sign an authorization form: To receive research-related treatment in connection with research studies or to receive health care when the purpose is to create health care information for a third party. I also understand may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Olympic Dermatology & Laser Clinic in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form (available at Olympic Dermatology & Laser Clinic) or to write a letter to Olympic Dermatology.*

Protection after Disclosure: *I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.*

_____ _____
Signature of patient or legal authorized representative Date

Date Expiration: 30 days from the date signed