Bainbridge Skin Surgery
Consultative Dermatology

Authorization for the Release of Protected Health Information

Patient Name: ______________________________ Date of Birth: ______________________________

Previous Name: ______________________________ Phone Number: ______________________________

Information to be released by:

☐ Bainbridge Skin Surgery
271 Wyatt Way NE, Suite 108
Bainbridge Island, WA 98110
Phone: (206) 317-6911 / Fax: (206) 317-6975

☐ ______________________________
Clinic/Physician Name

____
Address

____
City, State, Zip

____
Phone Fax

Information to be released to:

☐ Bainbridge Skin Surgery
271 Wyatt Way NE, Suite 108
Bainbridge Island, WA 98110
Phone: (206) 317-6911 / Fax: (206) 317-6975

☐ ______________________________
Clinic/Physician Name

____
Address

____
City, State, Zip

____
Phone Fax

Purpose of disclosure (check all that apply):

- ☐ Personal
- ☐ Transfer of Care
- ☐ Insurance
- ☐ Legal
- ☐ Other: ______________________________

Information to be released (check all that apply):

- ☐ All Records
- ☐ Records dated from __________ to ___________
- ☐ Clinic/Surgical Notes
- ☐ Lab/Pathology Reports
- ☐ Other: ______________________________

SENSITIVE INFORMATION*: This authorization includes the release of the following sensitive information unless specifically excluded. Please check if you do <u>not</u> want this released:*

__Mental health __HIV/AIDS __Sexually transmitted diseases __Drug and alcohol use

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. I have the right to revoke or cancel this authorization, in writing, at any time.

This authorization expires ______________________________ (date or event).
Authorization will expire in 90 days if not otherwise specified.

____
Signature of patient or legally authorized individual Date Signed

____
Printed name if signed on behalf of the patient Relationship to patient (parent, legal guardian, POA)