clearchoice DERMATOLOGY

DERMATOLOGY & DERMATOLOGIC SURGERY
Ph: (541) 316-6575 | Fax: (541) 210-8913

REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RELEASE FROM:

Provider holding current patient's information:

Office Name

Provider First and Last Name

Mailing Address

City State Zip

Phone # Fax#

PATIENT INFORMATION:

I hereby authorize to use or disclose my PHI as indicated below to :

First Middle Last Name

DOB Gender

Mailing Address

City State Zip

Phone# Email

RELEASE TO:

I hereby authorize to use or disclose my PHI as indicated below to :

clearchoice DERMATOLOGY

Attention:_____

Mailing Address

Phone number Fax number

INFORMATION TO BE RELEASED:

For dates of service from _____ to _____

- □ Complete Medical Record
- □ Biopsy Report(s)
- □ Lab Report(s)
- □ Consultation Report(s)
- □ Surgical Procedures
  - □ Other _____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- □ Substance Abuse (Including alcohol/drug abuse)
- □ Mental Health
- □ Psychotherapy Notes
- □ HIV related information (including AIDS related testing)

This material shall not be transmitted to anyone without written consent or authorization as provided in these statues.

PURPOSE OF DISCLOSURE:

□ Changing physicians □Continuing Care □At my (patient) request □Second Opinion □Insurance □Legal
□ Other _____

RELEASE TYPE:

Check one: □Paper □Electronic □CD □USB fob
Check one: □Pick up □Mail □Fax Number _____ □Email Address _____

Comments:

_____

This authorization will expire two years from the request date. | A photocopy of this form will be considered as valid as the original. | Patient may revoke this authorization at any time by notifying us at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. | Patient's health care and payment for his/her health care will not be affected if patient refuse to sign this form. | Patient will receive a copy of this form after he/she signs it. By filling out the information above the patient has given us permission to request his/her medical records.

By signing below, I acknowledge that I have read and understand this Request form.

_____ _____ OR _____ _____
Request Date Patient Signature Parent/Legal Guardian/Authorized Person Signature Relationship to patient

_____ _____
Records Requested By Date

For Office Use Only

Date Request Filled _____ By _____

Original Date of Form: Effective Date: April, 2022

A health care provider or state health plan that receives an authorization to disclose protected health information may charge:

▪1 dollar for pages 1 through 10 | $0.50 per page for pages 11 through 50 | $0.25 for each additional page 51+ | Bonus charge of $5 if request for records is processed and records are mailed by first class mail to the requester within seven business days after the date of the request | Actual costs of preparing an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual | Postage costs