FRONTIER
DERMATOLOGY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Printed name of patient:	Previous name, if applicable:
Date of birth:	Daytime phone number:

Send information *to*:

Provider/Organization:	
Address:	
Phone number:	Fax number:

Information to be released *from*:

Provider/Organization:	
Address:	
Phone number:	Fax number:

Purpose of disclosure:

☐ Transfer of care ☐ Continuity of care ☐Specialist ☐ Personal ☐ Legal ☐Insurance

Information to be disclosed:

☐ Medical records within the last 2 years
☐ All medical records (all medical records per *Washington State Records Retention Guidelines)*
☐ Other (indicate specific procedures and dates of service)

I understand that the information in my medical record may include information relating to testing, diagnosis, or treatment for: HIV/AIDS virus, mental health/psychiatric disorders, sexually transmitted diseases, and drug and alcohol abuse/treatment. I authorize the release or disclosure of this type of information.

Minors (age 13-17):

A minor patient's consent is required in order to release information concerning care for: 1) conditions relating to the minor's sexuality including, but not limited to: contraception, pregnancy, and sexually transmitted diseases (age 14 and above); 2) alcohol and/or drug abuse (age 13 and above for WA / age 14 and above for OR); and 3) mental conditions (age 13 and above for WA / age 14 and above for OR).

I understand that once Frontier Derm Partners discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under privacy laws. I also understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). My authorization is required to take part in a research study and to receive health care when the purpose is to create health information for a third party. You have the right to revoke or cancel this authorization, in writing, at any time (see reverse).

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

Date:	Patient signature:
Date:	Daytime phone number:
Relationship to patient, if other than patient:	

How to Submit Your Request

- Hand-deliver to the nearest location
- Upload and submit through your patient portal
    - Messages > Compose Message > To* (choose appropriate practice) > Add Attachments > Send
    - Questions? Call 866-574-1428
- Fax to 503-362-8435

Cancellation Notice

According to the Uniform Health Information Act for the State of Washington, records shall be released within 30 days after receipt of a signed, dated release form. Since records are usually handled within 2 – 3 days after receipt, Frontier Derm Partners will not be held responsible for any release of medical information accomplished before receipt of a written notice of cancellation. Revocation takes place from the date of receipt of the written request.

Instructions for Canceling a Request:

- You must provide a written request asking for revocation/cancellation of the original record release.
- We need to have your complete name, date-of-birth, telephone number (home/work) and the name of the
  person/agency that you authorized to receive the medical information.
- After receipt of the notice, telephone confirmation will acknowledge your withdrawal of authorization.
- If the release has been accomplished, you will be notified. The release will be revoked for any further disclosure.