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/Individual:	
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).

AUTHORIZATION EXPIRATION

This authorization expires on _____ unless otherwise specified. This authorization will expire in 12 months, if not otherwise specified.

Date:	**Patient signature:**
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.