3911 Castlevale Rd, Yakima, WA 98901
Phone: 509-966-7899 Fax: 509-965-0414 (Medical Records)

Authorization to Release Health Care Information

Patient's Name: _____Date of Birth: _____

I HERBY AUTHORIZE: *VALLEY DERMATOLOGY ASSOCIATES:*

[ ] Release To: [ ] Obtain From: (Check one or Both)

Agency or Individual's Name: _____

Address: _____City, State:_____ Zip Code:_____

Phone #: _____ Fax #: _____

For the purpose of:
_____ Transfer of Care _____ Referral/Consultation _____Insurance
_____ Legal _____Other/Self

THE SPECIFIC INFORMATION TO BE RELEASED:

DATES OF TREATMENT: (FROM) _____ (TO) _____

__All Health Care Information __ Pathology Report __ Labs

__Photo(s) __Chart note(s) __ Other:_____

___I DO___I DO NOT *consent* to have my photo(s) to be use for the purpose of education/promotional purposes.

_____All Health Care Information including HIV/ sexually transmitted diseases, psychiatric disorders/mental health, or drug and /or alcohol use.

[ ] I understand, I may be charged $1.24 a page for the first thirty pages, 94 cents a page after that, and a $28 clerical fee. WAC 246-08-0400
[ ] I understand, I may be charged $25 to complete any third-party forms (i.e. AFLAC, Workers' compensation) and writing letters for compensation benefits. I understand that I may be charged for copying costs. This fee is the responsibility of the patient.

I release the attending physician and associates of Valley Dermatology and its staff from any liability arising from the release of this information. This authorization may be revoked at any time and only in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclosed it, at which time it may no longer be protected under Privacy laws.

Signature of patient/guardian: _____Date:_____