



AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT NAME: _____ DATE OF BIRTH _____
OTHER NAMES: _____
ADDRESS: _____ TELEPHONE: _____

PLEASE RELEASE MY RECORDS TO: CENTRAL OREGON DERMATOLOGY, PC
388 SW Bluff Drive
Bend, OR 97702
TELEPHONE: 541-678-0020 FAX: 541-323-2174

FROM: _____

Mail _____ Fax _____

_____ ALL HEALTH CARE RECORDS
_____ ONLY RELEASE RECORDS PERTAINING TO

THIS AUTHORIZATION EXPIRES ON _____ (ONLY GOOD FOR 1 YEAR)
YES _____ NO _____ I authorize the release of my Sexually Transmitted Disease (STD)
results, including HIV/AIDS testing, whether negative or positive
to the persons listed above.

YES _____ NO _____ I authorize the release of any records regarding drug, alcohol or
mental health treatments to the persons listed above

Patient Signature Date Signed

I fully understand that the entity that receives this information is not required to comply
with federal privacy information the information my no longer be protected.
I may REVOKE this authorization at any time. To Revoke this Authorization I must notify
Central Oregon Dermatology in writing. I understand that I do not have to sign this
authorization and that my refusal to sign in no way affects my treatment from Central
Oregon Dermatology, PC.