388 SW Bluff Drive
Bend Oregon 97702
Telephone: (541)-678-0020 Fax: (541)-323-2174

Authorization to Release Medical Information

Please Release my records:

(***Please include the Name, Address, Fax, and Phone number***)

TO: Central Oregon Dermatology: ___________

OR

____

____

Phone:_______________________ **Fax**:____________________

From: Central Oregon Dermatology: ___________

OR

____

____

Phone:_______________________ **Fax**:____________________

Please indicate if you prefer your records to be **Faxed**: _______________ **or** **Mailed**: _______________

(*Please indicate **ALL Records** OR **Specific Records** Below*)

Requested Records: ____

Yes_____ NO_____ I authorize the release of my Sexually Transmitted Disease (STD) results, including HIV/AIDS testing (negative or positive) to those listed above.

Yes_____ NO_____ I authorize the release of any records regarding drug, alcohol or mental health treatments to those listed above.

Patient Name: ___________________________________**Date of Birth**_____________

Address:_______________________________________ ______________________

City State Zip **Telephone Number**

____ ______________________

Patient Signature **Date Signed** .

This release will expire a year from the date signed. I fully understand that the entity who receives this information is not required to comply with Federal Privacy information and my information may no longer be protected. I may REVOKE this authorization at any time. To revoke this authorization, I must notify Central Oregon Dermatology PC 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.