**PUYALLUP DERMATOLOGY CLINIC, P.S.**

**Medical Records Request/Release Form**

**Patient Information**

Name:_____ Date of Birth:_____ Phone:_____

Address:_____ City/State:_____Zip Code:_____

**I Authorize Puyallup Dermatology to request/release healthcare information to:**

Facility/Clinic/Company:_____

Phone:_____ Fax:_____

Address:_____ City/State:_____Zip Code:_____

**I authorize the release/disclosure of the following healthcare information:**

☐ Visit Note(s) ☐ Immunization Record(s) ☐ Medication Record(s) ☐ Billing

☐ Pertinent Records ☐ Diagnostic Imaging Report(s) ☐ Laboratory Report(s) ☐ ALL RECORDS

☐ Other (describe)_____

**Dates of information to be disclosed:** From_____ to _____
**Purpose of disclosure:** ☐ Self ☐ Physician ☐ Insurance ☐ Other:_____
**Is disclosure to an employer or financial institution?** ☐ Yes ☐ No (if yes, authorization expires 1 year after signing)

This authorization may include the release of the following sensitive medical information **unless specifically excluded** (please check if you do **NOT** want this information released): ☐ Sexually Transmitted Disease ☐ AIDS/HIV Diagnoses Report(s) ☐ Alcohol/Drug Abuse or Treatment ☐ Reproductive Health Care Services ☐ Gender-Affirming Treatment

Puyallup Dermatology is hereby released from all legal responsibilities or liability for the release of the above-mentioned information.

**REDISCLOSURE:** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of Alcohol and Drug Abuse records, which are protected by Federal Confidentiality Rules that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such a revocation must be in writing to Puyallup Dermatology. I understand that I do not have to sign this authorization in order to receive Health Care treatment. I further understand that if I request records for personal use, or for parties not involved in my health care, there may be a charge.

**This authorization expires on**_____. If there is no expiration date given, this authorization will expire one year from the date of signature. If the disclosure is to an employer or financial institution this authorization expires 1 year after signing.

**Signature of Patient or Authorized Representative**

Printed Name:_____ Signature: _____

Date: ____ / ____ / _____

Relationship to Patient (if not self): _____

**Please Fax Or Mail Completed Form**

**Fax: (253)840-5519**

**2622 S. Meridian. Puyallup, WA 98373**