Robert B. Hopp, MD
Jeremy Peck, MD
Chris Carpenter, PA-C
Travis Henderson, PA-C
Julie Hereford, ARNP
Randall Clower, PA-C
Mary Lu Vait, DCNP
Jennifer Corbin, PA-C
Rebecca Eng, ARNP

# Authorization for Release of Medical Information

Patient's Name:__________________________________________Date of Birth: _________________________

Previous Name (If applicable):______________________________________Chart#: _______________________

Purpose of Request___________________________________________________________________________

Release of Records: **TO** or **FROM** (Please circle)

Center for Excellence in Dermatology
8901 W. Gage Blvd
Kennewick, WA 99336
Phone: 509-735-1100
Fax: 509-735-1180

Center for Excellence in Dermatology
1050 W Elm St., Ste 220
Hermiston, OR 97838
Phone: 541-289-4601
Fax: 735-1180

Release of Records: **TO** or **FROM** (Please circle)

Provider/ Facility / Individual: ___________________________________________________________________

Address: ____________________________________________________________________________________

City, State__________________________________________Zip Code:__________________________________

Phone:____________________________________________Fax: _______________________________________

Information Requested:

□ Healthcare information relating to the following treatment, condition, or dates of treatment:

□ All healthcare information

□ Other: _______________________________________________________________________

I would like to receive records via: MAIL FAX PICK UP PHONE CALL

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing, and/or treatment. **I also understand that in order to comply with the new HIPAA laws, my records need to be reviewed for accuracy and completeness before they are released to anyone. This review process may take up to the full 15 working days allowed by Washington state law.**

_____________________________________________________________________________________
Signature of patient or patient's authorized representative Date

_____________________________________________________________________________________
Relationship of status if signed by anyone other than patient (parent, legal guardian, etc.)