REED DERMATOLOGY
NORTHWEST

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize: _____

_____

_____

to use and/or disclose my protected health information as described below to:

Reed Dermatology Northwest_____
Stacy Reed, M.D._____
13305 NW Cornell Rd, Ste C_____
Portland, OR 97229_____
Fax # 866-742-0249 _____

For the following purposes: (describe each purpose of use/disclosure. If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)

- ☐ Release to another physician
- ☐ Information requested by an insurance carrier
- ☐ Continued patient care
- ☐ Self – for patient's own records
- ☐ Insurance Claim/Application
- ☐ Other: _____

I understand that:

THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE.

Type of Information to Be Disclosed

- ☐ Entire Medical Record
- ☐ Office Chart Notes
- ☐ Billing Statement
- ☐ Consultation
- ☐ Other _____
- ☐ Most Recent 5 year History
- ☐ History and Physical Exam
- ☐ Medical Records for Continuity of Care
- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Operative Reports

In addition, I authorize that this will include health information relation to (check if applicable):

☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing ☐ Mental Health Treatment

Expiration:

This authorization will expire 180 days from the date of signing or (insert date) _____

Patient Name: _____ Date of Birth:_____

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient's Representative (if applicable)

_____
Signature of Witness Date

Relationship to Patient (if applicable)

- ☐ Parent or Guardian of unemancipated minor
- ☐ Court Appointed guardian
- ☐ Executor/administrator of decedent's estate
- ☐ Power of Attorney