Mt. Shuksan Family
Medicine & Dermatology

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_____ DOB:_____

INFORMATION TO BE RELEASED FROM:

Provider Name/Facility:_____

Street Address:_____

City, State, Zip Code: _____

Phone #:_____ Fax #:_____

INFORMATION TO BE RELEASED TO:

Provider Name: _____ Facility:_____

Street Address:_____

City, State, Zip Code: _____

Phone #:_____ Fax #:_____

INFORMATION TO BE DISCLOSED (CHECK ONE):

- ☐ Most Recent (2 years) Medical Records
- ☐ All Medical Records
- ☐ Specific Information (Please Specify):_____

PURPOSE OF DISCLOSURE (CHECK ONE):

- ☐ Transfer of Care
- ☐ Coordinated Care
- ☐ Attorney
- ☐ Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. ***EXCLUDE** the following information from the records release (**please initial**):

____ Drug/Alcohol Abuse/Treatment ____ Sexually Transmitted Diseases ____ HIV/AIDS Virus ____Mental Health/Psychiatric Disorders

MY RIGHTS: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may redisclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

(Patient, Guardian, or Authorized Representative)

This authorization will expire 90 days from the date signed