PUYALLUP DERMATOLOGY CLINIC, P.S.
929 East Main Ave., Suite 210
Puyallup WA 98372
Phone: 253-841-2453 Fax: 253-840-5519

I understand my records are protected under state and federal confidentiality laws and cannot be disclosed without my written consent except in specific instance described by law. This consent is subject to revocation at any time, except to the extent of prior action already taken to comply with this request.

The undersigned hereby authorizes the release of medical information as follows:

Patient:_____
First Middle Last

Birthdate:_____

Address: _____

I authorize _____
Physician/Facility Name

_____
Complete address City State Zip Code

To release information regarding my medical care and treatment to:

Name: _____

Address: _____

_____

Describe information to be released: _____

Expiration: Unless otherwise noted this authorization will expire with the event.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

I understand the information disclosed may contain matter that is protected by federal and state law, including information which may relate to alcohol, drug and psychiatric treatment, AIDS and/or HIV testing and/or other sexually transmitted diseases. I specifically consent to the release of this information. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. If I have any questions about disclosure of my health information, I can contact Puyallup Dermatology's office manager at 253-841-2453 ext 225.

_____ _____
Signature of patient or legal representative Date

If legal representative, relationship to patient: _____