SNAKE RIVER DERMATOLOGY
Brock Andersen, MD
Jock Perkins, PA-C

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

PATIENT NAME: ______________________ DOB: ______________________

ADDRESS: ______________________ PHONE: ______________________

TO/FROM: ______________________ PHONE: ______________________

ADDRESS: ______________________ FAX: ______________________

TO/FROM: ______________________ PHONE: ______________________

ADDRESS: ______________________ FAX: ______________________

PURPOSE/NEED FOR RECORDS: ______________________

COPIES THAT NEED TO BE RELEASED: (CHECK ALL THAT APPLY)

___LABS
___PATHOLOGY
___PROCEDURE NOTES
___OTHER: ______________________

*THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM TODAY'S DATE UNLESS REVOKED IN WRITING.

THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME WITH THE EXCEPTION OF INFORMATION RELEASED PRIOR TO THE DATE OF THE WRITTEN REVOCATION. SNAKE RIVER DERMATOLOGY CANNOT CONDITION TREATMENT OR ELIGIBILITY OF BENEFITS ON WHETHER 'THE AUTHORIZATION' IS SIGNED, PROTECTED HEALTH INFORMATION, ONCE RELEASED, HAS THE POTENTIAL TO BE REDISCLOSED BY THE RECIPIENT AND IS NO LONGER PROTECTED BY SNAKE RIVER DERMATOLOGY.

SIGNATURE: ______________________ DATE: ______________________

WITNESS BY: ______________________ DATE: ______________________