Dermatology and Allergy Specialists of Olympia, PLLC.

AUTHORIZATION TO RECEIVE HEALTH CARE INFORMATION

Patient's Name: _____
(Print)
Date of Birth: _____ SSN: XXX-XXX-_____ (JUST LAST 4)

Previous Name: _____ **Identification Check**:_____
(If applicable)
MRN: _____

I request and authorize information to be released from:
(Requestor must have complete information)
Facility Name / Provider :_____
Address:_____
City, State:_____ Zip Code:_____
Phone:_____ Fax:_____

To: **Dermatology and Allergy Specialists of Olympia, PLLC**
304 West Bay Dr NW Ste #301 • Olympia, WA 98502
Phone: (360) 413-8760 Fax: (360) 413-8839

□ **Dr. Katy McCleery** □ **Dr. Kaley Myer** □ **Dr. Michael Elm** □ **Dr. Jacob Bauer**
□ **Andrea Cigliola, PA-C** □ **Sarra Vashchenko, PA-C** □ **Jennifer Winter, PA-C**

Please check which category this authorization applies to:

□ **ALL RECORDS** □ **AFTER __/__/___** □ **BEFORE __/__/____** □ **BETWEEN _____**
□ **OTHER:_____**

***Paper** chart notes exceeding one chart note will cost the patient $1.24/per page for first 30 pages, $.94/per page for each additional. Charge will not apply for records sent electronically – some charts greater than 30 pages may not be able to be sent electronically and will require payment.*
Records from other medical facilities will not be included. Our facility does not re-release medical information

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, 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 health care information relating to such diagnosis, testing or treatment. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided. There may be a fee involved for copies of records and it is the responsibility of the patient or signing party to provide payment before the records will be copied. All fees are regulated by the State of Washington and will not exceed amount allowed - **RCW 70.02.010 and WAC 246-08-400**. I also understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Dermatology and Allergy Specialists of Olympia, or you. This information may not be protected by the Federal privacy regulations.

_____
Signature of patient or patient's authorized representative Date signed

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED
Revocation of this authorization must be in writing