

LINDSEY FIX, MD
ERIC OLSON, MD
JORDAN COOK, DO



PHONE: 541-600-2017
FAX: 541-225-4864
21 HAYDEN BRIDGE WAY
SPRINGFIELD, OR 97477

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize by my signature below: **Evergreen Dermatology, LLC**, to send and disclose a copy of the specific health information described below.

I wish to transfer:

Records and Pathology Relating to Dermatology Care
--

I wish to transfer such records to:

Clinic name: _____
Clinic address: _____
Clinic Phone number: _____
Clinic Fax number: _____

The Transfer is for the purpose of:

Reason for sending records: _____

If the above health information contains any of the four types of records or information listed below, additional laws relating to the use and disclosure of that information may apply. I understand and agree that this information will be disclosed and could be redisclosed if I place my initials in the applicable space next to the type of information.

- _____ HIV/AIDS Information
- _____ Mental Health Information
- _____ Genetic testing Information
- _____ Drug/alcohol diagnosis, treatment, or referral Information

I acknowledge that by my signature below the information in my authorization may be subject to redisclosure and therefore no longer protected under federal law. I also understand that federal or state law may restrict the redisclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information.

Initials: _____

I am giving this authorization of my own volition and understand that if I refuse to transfer my health information my ability to receive health care services or reimbursement for service solely for the purpose of providing health information to someone else, then my authorization is necessary to make that disclosure.

I understand that I may revoke this authorization in writing at any time. I further understand that if I revoke this authorization, the information described above may no longer be used or disclosed for the purposes described herein.

I understand that to revoke this authorization, a written statement to Evergreen Dermatology at 21 Hayden Bridge Way, Springfield, OR 97477 must be provided.

SIGNATURE

I have read this authorization and I understand it.

Signature of patient, Guardian or Healthcare Power of Attorney Date

Printed name Date of Birth