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Joshua May, MD
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2747 NE Conners Ave, Bend OR 97701
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Phone#: _____

I request and authorize _____
(**Name, Fax, phone# of organization**)

FAX: _____ **PHONE#:** _____

TO RELEASE RECORDS TO: Name: _____

Address: _____

O Mail **O Fax** City: _____ State: _____ Zip Code: _____

FAX: _____ **PHONE#:** _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

I understand that if the person or entity that receives this information is not required to comply with federal privacy protection regulations, the released information may be re-disclosed and may no longer be protected. I understand that I may revoke this authorization at anytime. To revoke this authorization I must notify Bend Dermatology Clinic with a letter written to the attention of the medical records department. I am aware that my revocation will not affect any actions taken by Bend Dermatology Clinic before the medical records department receives my revocation. I understand that I do not have to sign this authorization and that my refusal to sign in no way affects my treatment from Bend Dermatology Clinic.

THIS AUTHORIZATION EXPIRES UPON _____OR ONE YEAR AFTER IT IS SIGNED.