MICHELE M. THOMPSON, M.D.
DERMATOLOGY

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Authorization for Release of Medical Records

Date: ______________________________

Patient Name: ______________________________ Date of Birth.: ______ /______/ ____________

Patient Address: ______________________________ Phone Number: ____________________

Person authorizing release of records: ☐ Patient ☐ Parent/Legal Guardian ☐ Other ____________________

RELEASE RECORDS FROM:

Doctor/ Clinic: ______________________________

Address ______________________________

Phone: ______________________________

Fax: ______________________________

TO BE SENT TO:

Michele M Thompson, MD
1499 SE Tech Center Place, Suite 135
phone: 360.450.6800
fax: 360.989.1150

☐ Send entire medical record.

☐ Limit record to the following treatment: ______________________________

☐ Limit record to the following time period: ______________________________

Reason for disclosure or use:
☐ Personal Use ☐ Transfer of Care ☐ Insurance ☐ Second Opinion ☐ Attorney ☐ Primary Care Review
☐ Other: ______________________________

I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that I have the right to withdraw permission for the release of my information at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed. Unless revoked earlier this authorization will expire 180 days from the date of signing below. I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

Patient Signature: ______________________________ Date: ______________

Or Signed by Personal Representative: ______________________________ Date: ______________

On Behalf of: ______________________________

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