Dermatology Specialists of Spokane

Richard S. Herdener, MD
Katherine Bruya Reed, MD
Ashley Lundgren, MD
Desiree Barclift, MCH, PA-C
Amanda Taylor, PA-C
Regan Brown, PA-C

Medical Records Release Form

Telephone: 509-456-8444 Fax: 509-455-9227

Patient Name: _____ Date of Birth: _____

Address: _____

Phone #:_____ Email address: _____

☐ **Send Medical Information** ☐ **Obtain Medical Information**

_____
Name of Person or Entity to Receive/Release Information

_____
Title (Physician, Therapist, Attorney)

_____
Street Address

_____
City, State & Zip Code

_____
Phone #

_____ All Records or Specific Date Range- All-_____Dates-_____
Fax #

I do not have to sign this authorization in order to receive treatment from Dermatology Specialists of Spokane. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Dermatology Specialists of Spokane.

_____ _____
Patient Signature/(Parent or guardian, if minor child) Date

_____ _____
Dermatology Specialists of Spokane Staff Signature Date