CLINIC 5C
WELCOME TO THE NEXT LEVEL

Phone: (509) 252-1299
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Medical Records Release

PATIENT INFORMATION		
LAST NAME	FIRST NAME	
EMAIL	PHONE	DATE OF BIRTH
ADDRESS		

Information to be Released:

- ☐ All Records
- ☐ Pathology Reports
- ☐ Mohs Procedure Notes
- ☐ Chart Notes
- ☐ Lab Reports
- ☐ Other: _____

Records from Date Range: ☐ From _____ to _____ or ☐ All Records

Reason for Request: ☐ Ongoing/Continuation of Care ☐ Other: _____

The above information may be released **to**:

_____
Name of Person or Entity to Receive Information

_____
Street Address City, State & Zip Code

_____ _____
Phone # Fax #

Requesting medical records **from:**

_____
Name of Person or Entity to Release Information

_____
Street Address City, State & Zip Code

_____ _____
Phone # Fax #

I understand that my medical records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that I do not have to sign this authorization in order to receive treatment from Clinic 5C. Information used or disclosed pursuant to this authorization 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 Clinic 5C By signing, I authorize the release of information specified above.

_____ _____
Patient / Agent / Guardian Signature **Date** **Print Name**