

Northwest Dermatology & Skin Cancer Clinic

21600 Highway 99, Suite 280, Edmonds, WA 98026
Tele (425)774-2616, Fax (425) 774-2660

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Date of Birth _____
(please print) Last First Middle I.

Address _____

City/State _____ Zip _____

Phone Number _____

I hereby authorize Northwest Dermatology & Skin Cancer Clinic to release a copy of my medical records to:

Name: _____

Institution: _____

Address: _____

City/State: _____ Zip: _____

This request and authorization applies to:

____ Health care information relating to the following treatment, conditions, or dates of treatment: _____

____ All health care information

____ Other: _____

I do ____ do not ____ specifically consent to release of any records which may include information
(initials) (initials)
regarding sexually transmitted diseases, including HIV (AIDS), alcohol, drug abuse, and/or mental health.
(This authorization is given pursuant to Washington law, including, but not limited to, RCW 70.24 et. Seq.)

I hereby release Northwest Dermatology & Skin Cancer Clinic and its staff from all legal responsibility that may arise from the act hereby authorized.

Patients Signature _____ Date _____

Parent or Legal Guardian _____
(if patient has not reached his or her fourteenth birthday)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

Date Received: _____ Date Sent: _____ By: _____