

# 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:

Name: \_\_\_\_\_

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City & State: \_\_\_\_\_ Zip: \_\_\_\_\_

To release my medical records to:

Dr. \_\_\_\_\_

Northwest Dermatology & Skin Cancer Clinic

21600 Highway 99, Suite 280

Edmonds, WA 98026

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: \_\_\_\_\_