21600 HWY 99, SUITE 280
EDMONDS, WA 98026
FAX: 425-774-2660
PHONE: 425-774-2616

FOR OFFICE USE ONLY:
Date received:____________________
Date sent:______________________
Initials:________________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

This form must be filled out COMPLETELY by the patient or patient's guardian

Patient Name:____ Date of Birth:________________________

Previous Name:____ Phone Number:______________________

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
☐ Northwest Dermatology	☐ Northwest Dermatology
☐ ______________________________	☐ ______________________________
Organization/Person Name	Organization/Person Name
______________________________	______________________________
Address	Address
______________________________	______________________________
City, State, Zip	City, State, Zip
______________________________	______________________________
Phone Fax	Phone Fax

This request and authorization applies to (initial all that apply):
___My health information relating only to the following treatment or condition__________________
___My health information only for the following dates:_______________________________________
___All health care information in my medical record
___Other:____

***SENSITIVE INFORMATION**: This authorization includes the release of the following sensitive information unless specifically excluded. Please check if you do not want this released: __Mental health __HIV/AIDS __Sexually transmitted diseases __Drug and alcohol use*

REASON FOR REQUEST: __Personal __Transfer of Care __Insurance __Legal Review __Other________________________________

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. I have the right to revoke or cancel this authorization, in writing, at any time. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

This authorization expires______________(date or event). Authorization will expire in 90 days if not otherwise specified.

____
Patient or legally authorized individual signature Date Time

____
Printed name if signed on behalf of the patient Relationship to patient(parent, legal guardian, POA)