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AUTHORIZATION FOR MEDICAL RECORDS RELEASE

I, _____
(Please print full legal name and any known alias)

Birth Date: _____ Social Security Number: _____

I hereby authorize: _____
(Doctor's Name)

(Address, Phone and Fax Number)

To release health care information of the patient named above to:

(Doctor's Name)

(Address, Phone and Fax Number)

_____ All Medical Records _____ Lab Reports _____ Pathology Reports
_____ Operative Notes _____ Other: _____

I understand that my records may contain information regarding the diagnosis and treatment of HIV (Aids Virus), sexually transmitted diseases, and drug or alcohol abuse, mental illness or psychiatric treatment.

I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment enrollment, or eligibility for benefits). RCW 43.70.510

I give my specific authorization for these medical records to be released.

Signature _____ Date _____

*Authorization will expire 365 days from signature date.

** Please complete this form then fax or mail it to the office which you are requesting records from.

Federal and state laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general release is not sufficient. 42 CFR Part 2: RCW 70.02.300

The PHI (Personal Health Information) contained in this facsimile is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of federal law (HIPPA) and will be reported as such.