NORTHWEST SKIN SPECIALISTS, PLLC
1229 Madison Street, Suite 1290
Seattle, WA 98104
Phone: (206) 315-4600
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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.