

DERMATOLOGY ASSOCIATES

P.L.L.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

Address: _____ City/State: _____

Zip Code: _____ Phone Number: _____

I request and authorize:

Name: _____

Address: _____

City/State: _____ Zip Code: _____

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

Dermatology Associates, PLLC
1730 Minor Avenue, Suite 1000
Seattle, WA
98101

This request and authorization applies to: (Check one)

_____ Health care information relating to the following treatment, condition or dates of
treatment: DERMATOLOGY

_____ Other: _____

If I have been tested, diagnosed, or treated for HIV/AIDS virus, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature of patient or patient's authorized representative

Date Signed

Relationship or status if signed by anyone other than patient

Please send records under 15 pages via fax otherwise, by mail.

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED.
(POSSIBLE COPYING FEE REQUIRED)

Phone: 206-267-2100

Fax: 206-267-2101

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