Lake Washington
DERMATOLOGY
An Affiliate of North Pacific Dermatology

10117 NE 58th Street Suite 200
Phone (425) 821-6363
Fax (425) 821-4804

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Patient's Phone #: ( ) _____

Date of Request: _____ **Date Needed:** _____

☐ I authorize Lake Washington Dermatology to
RELEASE INFORMATION TO:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/ Fax # (include area code)

OR

☐ I authorize Lake Washington Dermatology to
OBTAIN INFORMATION FROM:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/ Fax # (include area code)

TYPE OF RECORDS REQUESTED:
☐ All medical records
☐ Dates specific
☐ Other: _____

THE PURPOSE OF THIS DISCLOSURE:
☐ Continuation of care
☐ Referral
☐ Other: _____

Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to, and including today's date. I understand the information in my medical health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to; take part in a research study, or receive health care when the purpose is to create health care information for a third party.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Lake Washington Dermatology based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must write a letter to Lake Washington Dermatology.
This Authorization expires 90 days after the date it is signed.
I have read the above foregoing authorization for release of medical information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____
Signature of Patient/Parent/Guardian/ Authorized Representative Date

_____ _____
Printed name of authorized representative Relationship to patient