Dermatology of Seattle
13610 First Avenue South, Seattle, WA 98168
206-248-5020 – 206-244-8425 (fax)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____
SSN: _____ Previous Name: _____

I request and authorize: Name: _____
Address: _____
City/State/Zip: _____
Phone: _____Fax: _____

to release the healthcare information of the patient named above to:
Name: _____
Address: _____
City/State/Zip: _____
Phone: _____Fax: _____

This request and authorization applies to: (please initial the appropriate box)

- ❑ Healthcare information relating to the following treatment, condition, or dates of treatment: _____
- ❑ All healthcare information **EXCLUDING** specific information relating to sexually transmitted diseases (including HIV/AIDS), alcohol or drug use, or visits related to psychiatric disorders/mental health.
- ❑ All healthcare information **INCLUDING** specific information relating to sexually transmitted diseases (including HIV/AIDS), alcohol or drug use, or visits related to psychiatric disorders/mental health.
- ❑ Other: _____

I understand that my express consent is required to release any healthcare information related to testing, diagnosis and/or treatment for HIV/AIDS virus, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV/AIDS virus, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing, or treatment.

_____ _____/_____/_____
Patient or patient's authorized representative Date

_____
Relationship or status if signed by anyone other than patient

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT WAS SIGNED