Aesthetic and General
Dermatology OF Seattle
Elie Levy MD & Associates
13610 First Avenue South
Burien, WA 98168

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:

Dermatology of Seattle
Address: **13610 1ST Ave South**
Burien, WA 98168

Phone: (206)-248-5020 Fax: (206)-244-8425

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: _____

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

_____
Relationship or status if signed by anyone other than patient

THIS AUTHORIZATION EXPIRES 90 AFTER THE DATE IT WAS SIGNED