Westside DERMATOLOGY

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME		DATE OF BIRTH	
SSN		PREVIOUS NAME	
ADDRESS		CITY, STATE	
ZIP CODE		PHONE NUMBER(S)	

I REQUEST AND AUTHORIZE:	NAME: ADDRESS: CITY, STATE, ZIP: PHONE:
TO RELEASE INFORMATION TO:	KELLI R. ARNTZEN, MD / SONJA M. KREJCI, MD / MARY ELLEN LUCHETTI, MD / KENDELL C. WILSKE, MD WESTSIDE DERMATOLOGY 4740 44TH AVENUE SW, #200 SEATTLE, WA 98116 FAX:206-937-1916
THIS REQUEST AND AUTHORIZATION APPLIES TO (CHECK ONE):	☐ Healthcare information relating to the treatment or condition of dermatology and/or pathology. ☐ Other: _____
THE PURPOSE OR NEED FOR THIS INFORMATION:	☐ Personal ☐ Transfer of Care ☐ Disability ☐ Insurance ☐ Legal Review ☐ Continuing Care ☐ Other: _____

I understand that the information in my health record may include information relation 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 or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below:

_____

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

_____ _____

Signature of patient or patient's authorized representative **Date**

_____

Relationship or status if signed by anyone other than the patient

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED