REQUEST AND CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby authorize ____
to release the following information from my medical record:

Patient Name: ____

Address: ____

Date of Birth: ______________________ SSN: ______________________

Information to release:

______ Dates of treatment, from ______________ to ______________

______ Information relating to the following treatment: ______________

____

______ Entire medical record

Information to be released to:

The Bellevue Laser & Cosmetic Center
1200 112th Ave. N.E., Suite C-187
Bellevue, WA 98004
Ph: 425 732-2677 Fax: 425 457-7499

Purpose of disclosure: ____

I understand this consent can be revoked at any time except to the extent that disclosure in good faith has already occurred in reliance on this consent.

Patient/Representative Signature: ______________________________________

Relationship: ____

Date: ______________________

Witness Signature: ____