

REQUEST AND CONSENT FOR RELEASE OF MEDICAL RECORDS

Date: _____

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

Patient Name: _____

Address: _____

Date of Birth: _____ SSN: _____

Information is to be released from:

Please fill out name, address, phone and fax number of medical office you want your information released from

Information to release:

___ Dates of treatment, from _____ to _____

___ Information relating to the following treatment: _____

___ Entire medical record

Purpose of disclosure: _____

Information is to be released to: **Bellevue Laser & Cosmetic Center**
1200 112th Ave NE, Suite C-187
Bellevue, WA 98004
Ph: 425-732-2677 Fax: 425-974-1233

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: _____