1600 Continental Place, Ste # 103
Mount Vernon, WA 98273
360-336-1947

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

_____ _____
PRINTED NAME OF PATIENT PREVIOUS NAME, IF APPLICABLE

_____ _____
DATE OF BIRTH DAYTIME PHONE NUMBER

SEND INFORMATION TO:
Provider/Organization: _____

Address: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED FROM:
Provider/Organization: _____

Address: _____

Phone: _____ Fax: _____

INFORMATION TO BE DISCLOSED:

- Medical records within the last 2 years
- All medical records (all medical records per Washington State Records Retention Guidelines)
- Other (indicate specific procedures and dates of service) _____

I understand that the information in my medical record may include information relating to testing, diagnosis, or treatment for: HIV/AIDS virus, mental health/psychiatric disorders, sexually transmitted diseases, and drug and alcohol abuse/treatment. I authorize the release or disclosure of this type of information.

I understand that once Cascade Facial Surgery & Aesthetics discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws. I also understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment

This authorization expires _____ (date or event). Authorization will expire in 90 days if not otherwise specified.

_____ _____
DATE PATIENT SIGNATURE

_____ _____
DATE PARENT OR LEGAL GUARDIAN