Samir Master, MD

Casey Carlos, MD, PhD

Authorization for Release of Medical Information

Patient Name _________________________ **Date of Birth** _________________________

Previous Name (if applicable) ____

Purpose of request ____

Release of Records: To or From

□ Dermatology Arts
832 102nd Avenue NE
Bellevue, WA 98004
Phone: 425-753-2918
Fax: 425-333-7389

□ Dermatology Arts
1701 Creekside Loop, #120
Yakima, WA 98902
Phone: 509-853-7546
Fax: 509-852-7565

Release of Records: To or From

Provider/Facility/Individual ____

Address ____

City, State ___________________________________ Zip Code ______________________

Phone _______________________________________ Fax __________________________

Information Requested:

□ Clinical Notes ____

□ Laboratory/Pathology reports ____

□ Imaging studies (X-ray, CT scan, MRI) ____

□ Other ____

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it, and would then be no longer be protected by federal regulations.

____ ____________________ __________

Patient or legally authorized individual signature | Relationship to patient | Date