Kirkland Dermatology Associates, PLLC

AUTHORIZATION TO USE, DISCLOSE, & RELEASE PROTECTED HEALTH INFORMATION

I authorized Kirkland Dermatology to use and disclose a copy of the specific health information described below regarding:

Patient's Name: _____ DOB: _____

Patient's Address: _____ Phone: _____

Please obtain information from:
Name of provider/Clinic/Organization: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please send information to:
Name of provider/Clinic/Organization: **Kirkland Dermatology Associates**

Address: 11800 NE 128th Street SUITE 450 City: Kirkland State: WA Zip: 98034

Phone: (425)899-3376 Fax: **(425) 899-4131**

For the range of dates from: _____ to: _____

Information to be disclosed:

For information related to the following diagnosis: _____

____ All Dermatology related records including pathology

OR

☐ Visit notes
☐ Pathology reports
☐ Labs or Bloodwork
☐ Photos
☐ Operative reports

Unless revoked, this authorization expires in 180 days or on this date: _____

Terms: This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of sexually transmitted disease, AIDS, HIV infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.

Patient Signature: _____Date: _____