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:

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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-240
Bellevue, WA 98004
Ph. 425-732-2677 Fax 425-974-1233

I understand that 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: ____