DERMATOPATHOLOGY NORTHWEST

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Dermatopathology Northwest, PLLC to disclose the following information from the health record of:

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

City, State, Zip: _____ Cell Phone: _____

Email Address: _____ Accession # _____

Covering the period(s) of health care: From (date): _____ To (date): _____

Information to be disclosed**:**

- ☐ Pathology reports
- ☐ Pathology slides and Paraffin Blocks (can only be released to a treating facility)
- ☐ Other (please specify) _____

This information is to be disclosed to: _____

Address: _____

For the purpose of: _____

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

Signed: _____

(Patient) (Date)

OR Personal Representative _____ **Relationship** _____ **Date** _____

Please include a copy of the requestor's identification when submitting this form.

Paperwork can be emailed to info@dermpathnw.com or faxed to (425) 455-9947. Requested medical records will be mailed via USPS to the address provided above.