Miller Family Dermatology

450 NW Gilman Blvd, Ste 301
Issaquah, WA 98027

Authorization for Release of Medical Information
Please read and complete the entire form for us to process this request

Patient Name: _____ Date of Birth: _____

*Previous Name (if applicable): _____

Release of Records: ☐ To **OR** From ☐

450 NW Gilman Blvd, Suite 301
Issaquah, WA 98027
Phone: (425) 654-1275
Fax: (425)654-0539

Provider/Facility/Individual: _____

Address: _____

City:_____State:_____ZIP:_____

Phone:_____Fax:_____

Information Requested:

Clinical Notes: _____

Laboratory/Pathology Reports: _____

Other: _____

_____ _____ _____

Patient/Authorized Signature ***Relationship to Patient*** ***Date***

I hereby authorize disclosure of health information for the above Facility/Provider/Patient listed. 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 will not affect any information release prior to notification of cancellation. I understand that the information disclosed may be subject to re-disclosure by the person/facility receiving it and would then be no longer protected by federal regulations.