PROSTATE CANCER CENTER OF SEATTLE

9730 3rd Avenue NE, Suite 208
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WWW.PROSTATECANCERCENTEROFSEATTLE.COM

REQUEST FOR MEDICAL INFORMATION

ATTN: MEDICAL RECORDS DEPARTMENT - RELEASE OF MEDICAL INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION
*TO FACILITATE IDENTIFICATION OF THIS RECORD AND RETURN BY **JUNE 1, 2016***
FAX (206) 525-5321 OR MAIL 9730 3rd AVE NE STE. 208 SEATTLE, WA 98115

NAME____
Last First Middle

ADDRESS____
Street *City* *State* *Zip*

TELEPHONE (___)__________________ SOCIAL SECURITY NUMBER____________________

EMAIL ADDRESS____________ BIRTHDATE_____________ PHYSICIAN'S NAME_____________

DATES OF MEDICAL CARE____

I authorize the Prostate Cancer Center of Seattle to release any and all information contained in my medical records to:

Doctor/Clinic/Patient:____

Address:____
Street *City* *State* *Zip*

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment of sexually transmitted disease, substance abuse or mental health conditions.

I release the Prostate Cancer Center of Seattle and its staff from all legal responsibility or liability that may arise from the release of this information. This consent may be revoked by me at any time, except when action has been taken.

PATIENT'S SIGNATURE_________________________________ Date ________________