

KENNETH D. FAW, MD PS
Board Certified
Adult & Pediatric Otolaryngology
Functional Endoscopic Sinus Surgery
Voice Disorders

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ of _____
(Name of Patient or Patient's Legal Guardian) (Address)

_____, _____ hereby
(City) (State) (Zip Code)

authorize _____ to disclose to

_____ any information you may have regarding my or my dependant's health or medical care. This includes pertinent x-ray or laboratory findings, drug or alcohol use or abuse, mental illnesses, HIV/AIDS, sexually transmitted diseases or immunizations for the period from _____ to _____.

I understand that my or my dependant's records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise permitted by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken relative to it.

Send Information To:

Fax: _____

Address: _____

Patient's name: _____

Patient's Birth date: _____

Date: _____

Signature of Patient: _____

Signature of Parent/Guardian (if applicable): _____

Witness: _____

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