STEVEN KAI CHAO, M.D., PH.D.
5325 BALLARD AVENUE NW, SUITE 209
SEATTLE, WA 98107

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ , hereby authorize the release of medical
PATIENT/PARENT

records for _____ between (to and from)
PATIENT NAME

Dr. Steven Chao and the following individual/organization:

_____
NAME

_____
STREET ADDRESS CITY STATE ZIP CODE

_____
TELEPHONE NUMBER FAX NUMBER

_____
EMAIL ADDRESS

The following forms of communication are permitted (please mark all that apply):

- o telephone
- o written
- o fax
- o email (including pdf attachments)

This authorization will expire in one year, unless otherwise specified.

I understand that I may revoke this authorization at any time, in writing. However, revocation of this authorization is not retroactive; it does not apply to communication that has already occurred.

_____
NAME OF PATIENT DATE OF BIRTH

_____
SIGNATURE OF PATIENT/PARENT DATE