

AUTHORIZATION TO EXAMINE RECORDS AND RELEASE

I, the parent of _____, do hereby authorize the Snohomish County Medical Society, a Washington corporation, and any of its duly constituted and authorized officers, agents, and committees, particularly the Grievance Committee and any member thereof, to examine any and all of my child's records, files, x-rays, and other data which may be in the possession, custody or control of

Doctor(s) _____

Whose address is _____

or which may be in the possession, custody, or control of any hospital in Snohomish County where my child was attended by the aforementioned physician.

I do further request the said doctor(s) and hospital to make a full disclosure of any and all information contained in said files, records, x-rays, and other data concerning my child's case, in accordance herewith. I understand that this authorization, **UNLESS SPECIFICALLY LIMITED BY ME IN WRITING BELOW**, will extend to all of my child's medical records including **TESTING FOR ALL SEXUALLY TRANSMITTED DISEASES, INCLUDING AIDS AND HEPATITIS**, as well as drug/alcohol, and/or psychiatric information.

EXCLUSIONS: IDENTIFY ANY SPECIFIC PORTION OF THE MEDICAL RECORD YOU DO NOT WISH RELEASED

Patient's Name (Please Print or Type)

Signed (If Patient a Child, Parent's Signature)

Date Signed

Address

Phone: Day Evening

I have discussed this with above named doctor(s). ___ Yes ___ No