

CONFIDENTIAL MEDICAL INFORMATION RELEASE REQUEST

I hereby authorize:

Facility name/Doctor: _____

Address: _____

City/State/Zip: _____

To release the following information from the health records of:

Name: _____

Date of Birth: _____ Daytime telephone: _____

Information to be released:

Dates of treatment:

____ Copy of complete health records. From _____ to _____
____ Lab Results.
____ Other: _____

Information is to be released to:

**COREhealth
Robert M. Schore, MD
2727 Hollycroft Street, Suite 390
Gig Harbor, WA 98335
Tel: (253) 857-8000**

I understand that some of the information released may include history of drug and/or alcohol abuse, sexually transmitted diseases, personal information about my mental/emotional status/treatment, and HIV status/treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____