PREMIER DIABETES CARE

Premier Diabetes Care
16404 Smokey Point Blvd. STE 102,
Arlington, WA 98223

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

The person named above hereby authorizes Premier Diabetes Care to:

- Request health information from the facility or provider below
- Send health information to the facility or provider below

Name of Facility or Provider: _____

Address: _____

Phone: _____ Fax: _____

Scope of Health Information Request

All health information regarding assessment, diagnosis, treatments, and lab results relating to diabetes mellitus during the last 3 visits or within the last 6 months

Other information (specify): _____

Authorization

This authorization will expire once the requested information is received or sent unless the exact date or timeline is specified: _____

Patient Name (Print): _____

Signature: _____ Date: _____

Name of Representative (if not patient): _____

Representative Signature: _____ Relation: _____

Mailing Address:
16404 Smokey Point Blvd, STE 102
Arlington, WA 98223

Phone: (425) 318-7144
Email: Info@PremierDiabetesCare.com
Website: www.PremierDiabetesCare.com