



Date: _____

Patient Name: _____

Date of Birth: _____

I hereby authorize Whidbey Community Physicians to release/disclose the following health care information:

- All health care information to include all diagnosis and lab results.
- Lab results only.
- Only health care information related to (specify):

_____ This authorization is effective until:

- Indefinitely
- Upon conclusion of a specified issue: _____
- Only until the date of: _____

Person(s) authorized to receive the above information:

_____ Relationship to patient _____
_____ Relationship to patient _____

_____ Patient of legally authorized individual signature

_____ Date

275 SE Cabot Drive, Suite B101
Oak Harbor, WA 98277
Office: (360)675-6648
Fax: (360)679-2487

5486 Harbor Avenue, P.O. Box 1087
Freeland, WA 98249
Office: (360)331-1363
Fax: (360)331-1372