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**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST FIRST M.I. MM/DD/YYYY

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I hereby authorize the disclosure of all medical records relating to my diagnosis and treatment of:

\_\_\_\_\_ to Dr. \_\_\_\_\_ of

Bastyr University Research Institute, Bastyr Clinical Research Center, 14500 Juanita Drive NE, Kenmore, WA 98028.

I understand that this medical records release authorizes research personnel to periodically review my medical records for up to 5 years in order to obtain information relating to my diagnosis, health, and any treatments relating to my diagnosis. Relevant medical record information may be obtained from any physicians that provide medical care or treatments relating to my diagnosis. I understand that information obtained from my medical chart will only be identifiable by a special study number and that my name will not appear on any reports of the results of these studies.

I understand that this authorization may be revoked in writing at any time. I understand that I am entitled to receive a copy of this authorization to keep for my records.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(PATIENT)

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*(OR LEGALLY AUTHORIZED REPRESENTATIVE AND RELATIONSHIP)*

**To Mail the Medical Records:**

Bastyr University Research Institute  
Attention: Bastyr Clinical Research Center  
14500 Juanita Dr. NE  
Kenmore WA 98028

**To Fax the Medical Records:**

(425) 602-3420