WHATCOM COUNTY MEDICAL SOCIETY
202 E. Holly St, #219
Bellingham, WA 98225
(360) 676-7630

AUTHORIZATION TO EXAMINE RECORDS AND

RELEASE MEDICAL RECORDS AND INFORMATION

I, the undersigned, do hereby authorize the Whatcom County Medical Society and/or Washington State Medical Association and/or Washington State Medical Quality Assurance Commission and/or their duly constituted and authorized officers, agents, and committees, particularly the Grievance Committee and any member thereof, to examine any and all of my records, files, X-rays, and other data pertinent to my medical treatment and my complaint which may be in the possession, custody, or control of the following physician(s) whose address(es) is (are):

1. ____________________
   ____
   ____

2. ____________________
   ____
   ____

3. ____________________
   ____
   ____

4. ____________________
   ____
   ____

or which may be in the possession, custody, or control of any hospital or other medical care facility where I was attended by the aforementioned physician(s); and grant permission for any of the above-named agents to interview any or all persons involved in said grievance.

I do further request the said physician(s) and hospital to make a full disclosure of any and all pertinent information contained in said files, records, X-rays, and other data concerning me and my case, in accordance herewith. I further understand that any and all information thus provided will be held in the strictest confidence and used only to evaluate my complaint.

In witness whereof, I hereunto set my hand the day and year first herein written.

____
Date

____
Signed

____
Address

____
City

____
Witness Signature

____
Phone Number

I have discussed this with the above physician(s). YES ____ NO ____

forms/112
7/96