UW Medicine

CENTER FOR PRECISION DIAGNOSTICS

MEDICAL RECORDS RELEASE FORM

RE: _____

DOB: _____

I hereby authorize the UW Center for Precision Diagnostics to request patient information or biological samples from:

Name: _____

Address: _____

_____

Zip Code

Telephone: (___) _____

Information to be released:

_____

_____

_____

This authorization is subject to my written cancellation at any time.

_____ _____

Signature of Patient, Parent/Guardian, or Authorized Next of Kin — Date

_____ _____

Witness — Date

Release to:
UW Medicine Center for Precision Diagnostics
Room H-561 Health Science Bldg.
1959 NE Pacific Street, University of Washington
Seattle, WA 98195-7655