Dr. Susan L. Marra
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PATIENT AUTHORIZATION TO DISCLOSE, RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

Patient's Name (*Please Print*):______________________________ **DOB**:____________

Patient Signature:____ **Date**:__________

Parent/Legal Guardian:____ **Date**:________________

Parent/Legal Guardian:____ **Date**:________________

Telephone #:____

INFORMATION TO BE RELEASED FROM:

Physician/Clinic/
Person:____

Address:____

City, State, Zip:____

Tel:________________________________ Fax:__________________________

INFORMATION TO BE RELEASED TO:

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Poulsbo, WA 98370
Tel: (206) 299-2676 Fax: (206) 522-7410

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