EYE ASSOCIATES NORTHWEST

Authorization to Release Medical Records

PATIENT INFORMATION

Name (print): _____ **DOB:** ____/____/_____

Please select one option from each column

Send records to ☐ or **Request records from** ☐	**Send records to** ☐ or **Request records from** ☐
If information is to be released by us, please complete this form and FAX or MAIL to: **Eye Associates Northwest, PC** 1101 Madison St #600 Seattle, WA 98104 **FAX:** 206-342-6166	**Name:**_____ **Address:**_____ **City/State/Zip:**_____ **Phone:** **FAX:**

INFORMATION TO BE RELEASE–Please select one

- ☐ Most recent 2 years chart notes, labs, special tests, operative reports, and glasses/contact prescriptions.
- ☐ All medical records
- ☐ Specific information (please specify):

REASON FOR DISCLOSURE–Please select one

- ☐ Attorney
- ☐ Insurance
- ☐ Doctor
- ☐ Personal

PATIENT AUTHORIZATION

I understand my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE from the records released (please initial)

_____Drug/Alcohol abuse/treatment and diagnosis
_____HIV/AIDS diagnosis/treatment/testing
_____Sexually transmitted disease
_____Mental illness or psychiatric diagnosis/treatment

MY RIGHTS

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

PRINT name:_____ Relationship:_____

Signature:_____ Date:___/___/_____
(Patient, Guardian or Authorized Representative)

This authorization will expire 90 days from the date signed.

Please allow 10 business days to process your request before calling: 206-342-6126

All requests are processed in the order they are received.

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