EYE ASSOCIATES
NORTHWEST, PC

Patient Authorization to Disclose, Release and/or Obtain Protected Health Information
PLEASE FILL OUT ALL SECTIONS TO AVOID DELAYS IN PROCESSING

Name: Last, First		Former Name(s)/Alias:	
Street Address	City	State	Zip
Person Number (if known)	Birthdate	Phone Number	

2. **Purpose or need for disclosure - may be released electronically. (Please check all applicable categories)**
   ☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify) _____

3. **(REQUIRED) Records to be released from:**
   ☐ Eye Associates Northwest
   ☐ Other:

4. **(REQUIRED) Records to be disclosed to:** (e.g. Insurance Company, Attorney, Physician, Patient)

Name		Telephone	Fax #
Street Address	City	State	Zip

5. **(REQUIRED) Records to be disclosed:**
   ☐ **Comprehensive overview** of chart (contains visit summaries, diagnostic tests, operative notes)
   From date: _____to date: _____
   (If timeframe not specified most recent 2 years of medical records will be provided)
   ☐ **Images** (specify type – e.g. external photos, OCT, VF) _____
   ☐ **Other** (**specify type (required)** – (e.g. discharge summary, operative reports, lab reports, billing records, or entire legal health record.) _____

   AND / OR:
   ☐ **I authorize VERBAL COMMUNICATION ONLY about my medical history and care.** (Checking this box means **no physical records will be sent** unless otherwise indicated by checking additional boxes in sections 5 & 7)

6. **Patient Authorization:** Unless otherwise indicated, I authorize sensitive information about my conditions, which may include sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include sensitive information about behavioral or mental health services and treatment for alcohol and drug abuse. ☐ **Do not include this sensitive information**.

7. **Format for Records:** (If VERBAL COMMUNICATION ONLY, this item may be skipped.)
   ☐ Paper (Fees may apply) ☐ Flash Drive ($10 charge) ☐ Email: _____

8. **This authorization is in effect until _____**(date) **OR 90 days from the date signed.**
   Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one year from the date signed by you.

Signature (Patient or person authorized to give authorization)	Date
If signed by person other than patient, provide printed name, reason, relationship to patient, description of their authority	

Phone: 206-215-2020 | Fax206-342-6166 | medicalrecords@eanw.net

Ballard Clinic & Surgery Center
1455 NW Leary Way Ste 300
Seattle WA 98107

First Hill Clinic
1101 Madison St, Ste 600
Seattle WA 98104

Kirkland Clinic
11325 NE 120th St
Kirkland WA 98034

Edmonds Clinic
21616 76th Ave W, Ste 110
Edmonds WA 98026

Northgate Clinic
155 NE 100th St, Ste 110
Seattle WA 98125

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By signing this page, I acknowledge that I have read and agree to the terms on both sides of this form.
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Minors: A minor patient's signature is required to release the following information (1) conditions relating to the minor's reproductive care (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

Patient Rights: I understand I do not have to sign this authorization to obtain healthcare benefits (treatment, payment, or enrollment). I may revoke this authorization at any time except to the extent already relied upon by sending a request in writing to Eye Associates Northwest. 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.

I understand I have the following rights to:
• Inspect or receive a copy of my protected health information.
• Receive a copy of this signed form.
• Refuse to sign this form for authorization to disclose or release my protected health information.

Please complete this form and return it to Eye Associates Northwest.

This authorization form can be sent to us by mail or by fax. If the patient chooses to accept the risks associated with unencrypted email (that email communications could potentially be read by a third party), the form may be sent by email.

Eye Associates Northwest
155 NE 100th Street, Ste 110
Seattle WA 98125
Email: medicalrecords@eanw.net

Fax: (206) 342-6166
Phone: -(206) 215-2020

EANW Staff Only: Records Released By:	Date released: