Edmonds Vision Center

201 5th Avenue South, Suite 102
Edmonds, WA 98020
Phone: 425. 771.7772 Fax: 425.775.9973

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Patient's Name____ Birth date_______________
(Please Print) LAST FIRST MI

Information to Be released ***BY:***	Information to Be released ***TO:***
☐ Edmonds Vision Center	☐ Edmonds Vision Center
Organization/Person's Name	Organization/Person's Name
Street Address City, State, Zip	Street Address City, State, Zip
Phone Fax	Phone Fax

TYPE OF INFORMATION REQUESTED

☐ Complete eye care medical record

☐ Complete medical record abstract (includes 3 years chart notes, most recent pathology and diagnostic imaging reports)

My health information relating to the following treatment or condition: ______________________________________

☐ My health information for the following date(s): ____

☐ Other:____

REASON FOR REQUEST: ☐ Personal ☐ Disability ☐ Insurance ☐ Legal Review ☐ Continuing Care ☐ Other

I understand that the information in my health record may in clued information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about the behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment unless specifically excluded below.

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MINORS AGE 13-17: A minor patient's signature is required to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to contraception, pregnancy and pregnancy termination, sterilization and sexually transmitted diseases (age 14 and older). (2) Alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).
I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information. You have the right to revoke or cancel this authorization in writing at any time. I understand that I do not have to sign this authorization to get health care benefits (treatments, payment, enrollment, or eligibility for benefits.)

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORDS UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICAN OR HEALTHCARE FACILITY.

This authorization expires _________________________(date or event) Authorization will expire in 90 days if not otherwise specified.

Patient Signature ____ Date _______________________

Parent or Legal Guardian____ Date _______________________

Relationship to patient if other than patient ____
(You may be requested to provide legal documentation as proof for power of attorney or guardianship)

Federal law prohibits the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42. CFR Part 2.