Authorization For Release of Medical Information

Patient Information:

Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

I hereby authorize Washington Eye Care to:

Release Information Obtain Information Exchange Information

With the following Organization or Person: _____

Address: _____ City:_____ State:___ Zip:_____

Email: _____ Telephone: _____ Fax: _____

Please Release the Following:

All information in my Medical Record

Health Care information in my Medical Record for the date(s): _____

Health Care information pertaining to the following treatment or condition: _____

Other Health Care information such as reports or lab results (Specify): _____

Exclude information (if applicable) pertaining to:

Mental Health Drug/Alcohol HIV/AIDS Communicable Treatment

Purpose of Need for Disclosure:

Continued Patient Care	Transfer of Patient Care	Personal Use	Attorney/Legal
Insurance Claim/Application	Disability Determination	Other (Specify) _____	

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

This Authorization Ends:

In 90 days after the date of my signature

When the following event occurs: _____

(no longer than 90 days from date signed)

Please Sign Below:

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name Relationship (Parent, Legal Guardian