Patient Authorization to Disclose, Release and/or Obtain Protected Health Information

Patient Name:____________________________________**Date of Birth:** ____/____/_____ **Telephone #:(**_____**)**_____________

If requesting a copy of your own records, how would you like to receive the information?

☐ Pick up:__________________________ ☐ Mail **(Please provide below)**
(from which clinic)

INFORMATION TO BE RELEASED FROM:	**INFORMATION TO BE RELEASED TO:**
☐ **EVERGREEN EYE CENTER** **716 S 348TH ST** **FEDERAL WAY, WA 98003** **P: (800)340-3595** **F: (206)212-2194** **OR:** ______________________________**(Name)** ______________________________**(Address)** ______________________________**(City, ST, Zip)** (YOU MUST SUPPLY AN ADDRESS) ______________________________**(Phone/Fax)**	______________________________**(Name)** ______________________________**(Address)** ______________________________**(City, ST, Zip)** (YOU MUST SUPPLY AN ADDRESS) ______________________________**(Phone/Fax)** **OR:** ☐ **EVERGREEN EYE CENTER** **716 S 348TH ST** **FEDERAL WAY, WA 98003** **P: (800)340-3595** **F: (206)212-2194**

PURPOSE OF DISCLOSURE:

☐ Personal ☐ Insurance ☐ Legal Matters ☐ Provider ☐ Other_________________________________
(please specify)

INFORMATION TO BE RELEASED:

☐ All health care information in my medical record.

☐ Health care information in my medical record relating to the following treatment or condition:

____

☐ Health care information from date **(YOU MUST INDICATE DATES)** start:___/___/____end:___/____/______

☐ Other (e.g., X-rays, bills, diagnostic tests), specify date(s):_____________________________________

Authorization: I understand that the records being requested may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. I give my specific authorization for this information to be released: Yes____No___

This authorization expires 90 days from the date signed OR on the date or event indicated:

____

Patient Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.

Once Evergreen Eye Center discloses your health information, the recipient may re-disclose your information and privacy laws may no longer protect your information.

____ ____
Patient or legally authorized individual signature Date

____ ____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

EEC Staff use only: Records released by:	Date released: