EVERGREEN EYE CENTER
Leading-edge, patient-centered care.

Robert A. Tester, MD
Gary W. Chung, MD
Brice R. Nicholson, DO
John J. Whitehead, MD
Andrew B. Kopstein, MD
Alexander L. Grigalunas, MD
Kelly M. Bui, MD
Laura M. Periman, MD
Bradley A. Frederickson, OD
James W. Santoro, OD

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

Name- Last, First,	Former Name(s)/Alias:		
Street Address	City	State	Zip
Medical Record 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. Records to be released from:

- Evergreen Eye Center
- Other:

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

Name	Telephone	Fax#	
Street Address	City	State	Zip

5. 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 and 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**.

6. Format for Records: ☐ Paper ☐ Flash Drive ($10 charge) If VERBAL COMMUNICATION ONLY, this item may be skipped.

7. 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	

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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.
Patient Authorization to Disclose, Release or Obtain Protected Health Information

Minors: A minor patient's signature is required in order 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 in order 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 Evergreen Eye Center PO Box 25020 Federal Way, WA 98093. 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 to 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 Evergreen Eye Center.

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:

Evergreen Eye Center
PO Box 25020
Federal Way, WA 98093
Fax: (855) 929-1515
Phone: (800) 340-3595
Email: MedicalRecords@evergreeneye.com

EEC Staff Only: Records Released By:	Date released:
	Rev: December 2019