

Records Request/Release

Patient Name: _____ DOB: _____

Guardian or Authorized Party Name (if applicable): _____

I authorize the use and disclosure of my health information as described below:

Information Requested:

- Records relating to treatment dates from: _____ to _____
- Records for all care at this facility or by this doctor
- Other (Please specify) _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, and/or treatment.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

Information to be Released: [] from [] to _____

[] from [] to Olympia Vision Clinic
1625 Cooper Point Rd SW
Olympia, WA 98502
(360) 357-6683 phone
(360) 754-0482 fax

[] from [] to Olympia Vision Clinic
5321 Corporate Center Loop SE
Lacey, WA 98503
(360) 459-2108 phone
(360) 459-2875 fax

Signature of Patient or Guardian

Date

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____

Print Name _____

Signature _____