Spokane Eye Clinic · 427 South Bernard · Spokane, WA 99204 · (509) 456-0107 · Fax (509) 747-2635

Release of Information Authorization

Patient Name:____ Phone: (_____)___________

Previous Name(s):____

Date of Birth: _________________________Age________ SSN:_______________________

Address: __________________________________City/State: _______________Zip Code: __________

Reason for Disclosure of Health Care Information:

☐ Changing doctors or clinic ☐ Continuing care (PCP, etc) ☐ School

☐ Insurance ☐ Legal ☐ Other _________________

FROM:

Name______________________________

Address____________________________

City/St/Zip__________________________

Phone_____________________________

Fax_______________________________

TO:

Name______________________________

Address____________________________

City/St/Zip__________________________

Phone_____________________________

Fax_______________________________

1. ☐ **Release of All Health Care Information, or**

2. ☐ **Release of Specific Health Care Information**

Information to release:

☐ Exam Notes
☐ Diagnostic Testing Reports
☐ Surgery
☐ Billing Information
☐ Other_____________________________

Dates of Service:

____
____
____
____
____

3. Information regarding **alcohol and drug use, sexually transmitted diseases (STD), HIV/AIDS, and mental health notes** cannot be released without your specific consent.

☐ I authorize release of: (check all that apply)

❒ Alcohol / drug use or treatment ❒ STD treatment ❒ HIV/AIDS ❒ Mental health

☐ I do not authorize the release of health care information pertaining alcohol, drugs, STD, HIV/AIDS or mental health notes.

Patients 14 years of age or older must authorize the release of this information. Patient signature is required if the patient is between 14 and 17 years of age:_____________________________________

I hereby authorize the above named physician or facility to release my medical records to the other above named physician or facility. I understand that the information disclosed may contain matter that is protected by Federal and state laws. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has not already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

☐ This authorization will expire in 90 days from the date signed, **or**

☐ This authorization will expire on ____________________(no longer than 90 days from date signed)

Signature____ Date____________________

Authorized representative name and relationship:_____________________________________

☐ Parent; Patient is under 18 years of age ☐ Legal guardian (documentation required)