Washington State law allows 15 business days from the receipt of this request to complete the request. Please allow this time to complete your request. (RCW 70.02.080)

Release of Information Authorization and Authorization to use or Disclose My Health Care Information (HIPAA 1 221)

Patient name: _____ Date of birth: _____

Previous name: _____ Phone Number: _____

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

☐ Changing doctors or clinic ☐ Continuity of care (PCP, etc.) ☐ School
☐ Insurance ☐ Legal
☐ For marketing purposes ☐ Other: _____

☐ Check here if Spokane Eye Clinic, Spokane Eye Surgery Center will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing

Please send my Health Care Information:

FROM:
Name_____
Address_____
City/St/Zip_____
Phone_____
Fax_____

TO:
Name_____
Address_____
City/St/Zip_____
Phone_____
Fax_____
Email_____

Send Records: ☐ Mail ☐ Fax ☐Encrypted Email ☐ Hand-delivered
☐Encrypted CD/DVD/USB Drive ☐Patient Portal

Spokane Eye Clinic or Spokane Eye Surgery Center may use or disclose the following health care information (check all that apply):

☐ **Release of All Health Care Information, OR**
☐ **Release of Specific Health Care Information** **Date(s) of Service**
- ☐ Exam Notes _____
- ☐ Diagnostic Testing Images _____
- ☐ Surgery _____
- ☐ Billing Information _____
- ☐ Other_____ _____

<u>Uses and Disclosures Requiring Specific Authorization:</u> You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

□ HIV/AIDS
□ Mental Health or Illness
□ Reproductive Care (minors only)
□ Sexually Transmitted Diseases
□ Drug and/or Alcohol Abuse

THIS IS A TWO SIDED FORM. PLEASE COMPLETE THE REQUIRED SIGNATURE PAGE ON THE BACK SIDE OF THE FORM. TURN OVER

Washington State law allows 15 business days from the receipt of this request to complete the request. Please allow this time to complete your request. (RCW 70.02.080)

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

This authorization will expire in 90 days, **or if you request sooner:** _____ (date)

II. My Rights

1. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - To receive research-related treatment in connection with research studies **or**
   - To receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Spokane Eye Clinic or Spokane Eye Surgery Center in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   •Fill out a revocation form. A form is available from Spokane Eye Clinic or Spokane Eye Surgery Center**]** or
   •Write a letter to Spokane Eye Clinic /Spokane Eye Surgery Center, 427 S. Bernard, Spokane WA 99204.

III. Protection after Disclosure. I understand once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Time

_____

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

_____

Minor patient's signature, if applicable Date Time

SPOKANE EYE CLINIC * 427 S. Bernard * Spokane WA 99204 * (509) 456-0107 FAX (509) 747-2635