Authorization to Release Health Care Information

NORTHWEST
EYE CLINIC

3015 Squalicum Parkway, Suite 260
Bellingham, WA. 98225
PH: 360- 733-4800 Fax: 360-733-2879

Patient Name: ___________________________________ **Date of Birth:** ______________________

Previous Name if applicable: ________________________ **Phone Number:** ________________

Please send my records *from*:	Please send my records *to*:
☐ **Northwest Eye Clinic** ☐ __________________________________ Providers Office/Person Name __________________________________ Fax __________________________________ Phone __________________________________ Address	☐ **Northwest Eye Clinic** ☐ __________________________________ Providers Office/Person Name __________________________________ Fax __________________________________ Phone __________________________________ Address

This authorization is limited to the following treatment from the dates of _________ to ________:

☐ All Clinical Records
☐ Clinical Records only related to ____
☐ Visual Fields ☐ Fundus Photos and/or Fluorescein Angiography
☐ Other ____

This authorization includes the release of sensitive information unless specifically excluded. Please check if you ***do not*** want this released:

☐ Mental Health ☐ HIV/AIDS ☐ Sexually transmitted diseases ☐ Drug & Alcohol Treatment

Reason for Request:

☐ Continued Medical Care ☐ Evaluation & Treatment ☐ Disability ☐ Insurance ☐ Legal
☐ Personal/Other: ____

This authorization ends:

☐ On (date): ____________ ☐ When the following event occurs: ______________________________________
☐ In 1 Year from the date signed unless specifically revoked.

I understand that my express consent is required to release health care information related to testing, diagnosis and treatment. I give my authorization to disclose my medical records to Northwest Eye Clinic. This authorization may be revoked at any time. If revoked, no actions already taken by NWEC based upon this authorization will be affected. Once protected health information is released by NWEC, it cannot be guaranteed that the recipient will not disclose the information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of health information.

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Signature of Patient or patient's authorized representative Relationship Date signed