 **Authorization to Release Medical Records**

**PATIENT INFORMATION**

**Name (print): DOB:**  / /

**Please select one option from each column**

|  |  |
| --- | --- |
| **Send records to** or **Request records from**  |  **Send records to** or **Request records from**  |
| If information is to be released by us, please complete this form and FAX or MAIL to: **Pacific Retina Center PLLC**1412 SW 43rd St. Suite 206 Renton, WA 98057**FAX:** (425) 988 – 0168 | **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Phone: FAX:**  |

**INFORMATION TO BE RELEASE**–Please select one  **REASON FOR DISCLOSURE**–Please select one

|  |  |
| --- | --- |
| * Most recent 6 months of chart notes, labs, special tests, operative reports, and glasses/contact prescriptions.
* All medical records
* Specific information (please specify):
 | * Attorney
* Insurance
* Doctor
* Personal
 |

**PATIENT AUTHORIZATION EXCLUDE from the records released** (please initial)

|  |  |
| --- | --- |
| I understand my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.  | \_\_\_\_\_Drug/Alcohol abuse/treatment and diagnosis \_\_\_\_\_HIV/AIDS diagnosis/treatment/testing \_\_\_\_\_Sexually transmitted disease \_\_\_\_\_Mental illness or psychiatric diagnosis/treatment  |

**MY RIGHTS**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may redisclose it, at which time it may no longer be protected under Privacy laws.

PRINT name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_\_\_\_ (Patient, Guardian or Authorized Representative)

**There is a $28 clerical fee plus $1.24 per page (WAC 246-08-400) for the release of medical records unless your copies are being sent to another physician or healthcare facility. Please allow 10 business days to process your request before calling: (253) 236-5720.**

July 2020