



Authorization to Release Medical Records

PATIENT INFORMATION

Name (print): _____ DOB: ____ / ____ / ____

Please select one option from each column

<p>Send records to <input type="checkbox"/> or Request records from <input type="checkbox"/></p> <p>If information is to be released by us, please complete this form and FAX or MAIL to:</p> <p>Pacific Retina Center PLLC 1412 SW 43rd St. Suite 206 Renton, WA 98057 FAX: (425) 988 – 0168</p>	<p>Send records to <input type="checkbox"/> or Request records from <input type="checkbox"/></p> <p>Name: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Phone: _____ FAX: _____</p>
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INFORMATION TO BE RELEASE—Please select one

REASON FOR DISCLOSURE—Please select one

<input type="checkbox"/> Most recent 6 months of chart notes, labs, special tests, operative reports, and glasses/contact prescriptions. <input type="checkbox"/> All medical records <input type="checkbox"/> Specific information (please specify): _____	<input type="checkbox"/> Attorney <input type="checkbox"/> Insurance <input type="checkbox"/> Doctor <input type="checkbox"/> Personal
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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
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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 re-disclose it, at which time it may no longer be protected under Privacy laws.

PRINT name: _____ Relationship: _____

Signature: _____ Date: ____/____/____

(Patient, Guardian or Authorized Representative)

This authorization will expire 90 days from the date signed.

Please allow 10 business days to process your request before calling: (253) 236 – 5720

All requests are processed in the order they are received.

There is a \$25 clerical fee for the release of medical records.