NORTHWEST EYE SURGEONS

Authorization to Release or Obtain Health Care Information

There may be a $25 charge for copies of your medical record unless your copies are being sent to another physician or healthcare facility. Records will be provided within 15 days (RCW70.02.080).

Patient Name: _____ Date of Birth: _____
(*Please Print*) LAST FIRST MI

Are medical records under another name? _____ Phone number: _____

INFORMATION TO BE RELEASED ***BY***:	INFORMATION TO BE RELEASED ***TO***:
❑ Northwest Eye Surgeons	❑ Northwest Eye Surgeons
❑ _____ Organization/Person Name	❑ _____ Organization/Person Name
_____ Street Address	_____ Street Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone Fax	_____ Phone Fax

TYPE OF MEDICAL RECORDS REQUESTED:
❑ Most recent date of service (no charge).
❑ Complete medical record abstract (includes 3 years of chart notes, most recent labs/pathology & diagnostic imaging reports).
❑ My health information only for the following date(s): _____
❑ Diagnostic imaging/photos
❑ Other: _____

SENSITIVE INFORMATION: This authorization includes the release of the following sensitive information unless specifically excluded. Please check if you do not want this released: ❑ Mental health ❑ HIV/AIDS ❑ Sexually transmitted diseases ❑ Drug and alcohol treatment

REASON FOR REQUEST: ❑ Personal (*There may be a $25 charge for copies of your medical record unless your copies are being sent to another physician or healthcare facility.*) ❑ Transfer of Care ❑ Disability ❑ Insurance ❑ Legal Review ❑ Other (please explain): _____

My Rights

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
- I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Northwest Eye Surgeons or another organization based upon this authorization.
- Authorization expires in 90 days.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship: parent, legal guardian, or personal representative

❑ 16404 Smokey Point Blvd Ste 303	Arlington, WA 98223	**360-658-6224**	888-655-6224	FAX: 360-658-6227
❑ 1306 Roosevelt Ave	Mount Vernon, WA 98273	**360-428-2020**	800-323-8498	FAX: 360-428-6918
❑ 10330 Meridian Ave N Ste 370	Seattle, WA 98133	**206-528-6000**	800-826-4631	FAX: 206-528-0014
❑ 795 N 5th Ave	Sequim, WA 98382	**360-683-2010**	800-246-9592	FAX: 360-683-2320
❑ 1412 SW 43rd St Ste 310	Renton, WA 98057	**425-235-1200**	888-404-6004	FAX: 425-917-9465