



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 :
<input type="checkbox"/> Northwest Eye Surgeons	<input type="checkbox"/> Northwest Eye Surgeons
<input type="checkbox"/> _____ Organization/Person Name	<input type="checkbox"/> _____ 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 365 days.

Patient or legally authorized individual signature Date

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

- | | | | |
|---|---------------------|--------------|-------------------|
| <input type="checkbox"/> 16404 Smokey Point Blvd Ste 303 Arlington, WA 98223 | 360-658-6224 | 888-655-6224 | FAX: 360-658-6227 |
| <input type="checkbox"/> 1306 Roosevelt Ave Mount Vernon, WA 98273 | 360-428-2020 | 800-323-8498 | FAX: 360-428-6918 |
| <input type="checkbox"/> 332 NE Northgate Way Seattle, WA 98125 | 206-528-6000 | 800-826-4631 | FAX: 206-528-0014 |
| <input type="checkbox"/> 795 N 5 th Ave Sequim, WA 98382 | 360-683-2010 | 800-246-9592 | FAX: 360-683-2320 |
| <input type="checkbox"/> 1412 SW 43 rd St Ste 310 Renton, WA 98057 | 425-235-1200 | 888-404-6004 | FAX: 425-917-9465 |