Redmond Eye Doctors
8630 164th AVE NE #100
Redmond, WA 98052
Ph: 425-885-7363 Fax: 425-861-5585

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____
Date of Birth: _____

I authorize the use and release of health information identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

RELEASE FROM: _____
_____
_____
_____

RELEASE TO: _____
_____
_____
_____

FOR THE PURPOSE OF FURTHER EYE CARE TREATMENT.

EXPIRATION DATE: 180 DAYS FROM THE DATE OF SIGNING.

It is completely your decision whether to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in the form.

_____ _____
Signature of Patient or Guardian Date

_____
Relationship, if signed by anyone other than patient