VANCOUVER EYE CARE
PHYSICIANS & SURGEONS

JOHN P. RUNDLE, M.D.
THERESA L. CLAYTON, M.D.
MICHAEL C. KIM, M.D.
SHAUYENE HSIEH, M.D.
MAURICIO R. CHAVEZ, M.D.

RICHARD L. DEGEN, O.D.
JEFFREY A. FRIES, O.D.
SAYGE M. HEINTZELMAN, O.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The undersigned hereby authorizes the release of medical information as follows:

Patient Information

_____
(First Name) (Middle Initial) (Last Name)

_____
(Address) (City) (State) (Zip)

_____
(Date of Birth) (Social Security Number) (Phone Number)

Authorization

I authorize:

Name: _____

Phone: _____

Fax: _____

☐ **Vancouver Eye Care, PS**
Main Street Clinic
Salmon Creek Clinic
Columbia Tech Center Clinic
Phone: (360) 696-4691
Fax: (360) 696-2078

To release information regarding my medical care and treatment to:

☐ **Vancouver Eye Care, PS**
Main Street Clinic
Salmon Creek Clinic
Columbia Tech Center Clinic
Phone: (360) 696-4691
Fax: (360) 696-2078

Name: _____

Phone: _____

Fax: _____

Information to be released:

☐ All eye care and treatment records
☐ Any outside medical records
☐ Visual Fields
☐ Operative Reports
☐ Fluoro. Angiogram
☐ CL Specs. & K readings
☐ Other _____

To be released in format: *Please select one*

☐ CD - $6.50 ☐ Fax - Free ☐ Paper - $25 Admin fee + $1.12/page (first 30pgs) $0.84 per additional page

Special Note: I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL AND DRUG ABUSE, PSYCHIATRIC DISORDERS AND TREAMENT, AIDS and/or HIV TESTING and/or OTHER SEXUALLY TRANSMITTED DISEASES.
I specifically consent to the release and disclosure of this information, including transmission of my medical records via facsimile (Fax) machine and/or encrypted email. Subsequent transfer of the records or disclosure of their content is prohibited without my specific consent.

This authorization expires 90 days after the date it is signed.

_____ _____
Signature of patient, authorized representative, parent or Guardian Date

_____
Relationship or status if signed by anyone other than the patient