

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:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> All eye care and treatment records | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Any outside medical records | <input type="checkbox"/> Fluoro. Angiogram | _____ |
| <input type="checkbox"/> Visual Fields | <input type="checkbox"/> CL Specs. & K readings | _____ |

 To be released in format: *Please select one*

-
- Fax - Free (no charge for faxing to another provider for coordination of care)
-
-
- CD - \$6.50
-
- 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 TREATMENT, 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 _____