Eye Doctors of Washington

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

NAME | Date of Birth

Daytime Phone | ADDRESS | CITY | STATE | ZIP

2) TO DISCLOSE TO:

☐ Self, Delivery Options: Pick up

☐ Mail to address above

☐ I hearby authorize_____to pick up my records (photo ID required)

☐ Encrypted Email to _____

Send To: ☐ Name & Address of Health Care Provider / Plan / other

_____

_____

3) DATE(S) OF INFORMATION TO BE DISCLOSED:

From (month/year) ☐ To (month/year) ☐ ☐ Entire Record

If left blank, only information from the past two (2) years will be disclosed.

4) PURPOSE: (check all that apply - **copy fees may apply***)

☐ Further Medical Care ☐ Legal Investigation / Action

☐ Insurance Eligibility / Benefits ☐ Personal (at my request)

☐ Other: _____

5) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that have the right to inspect and receive a copy of the health information I have authorized to be used and / or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that i do not need to sign this authorization in order to receive treatment. I am also aware that I may revoke this authorization by notifying the disclosing medical records/ health information department in writing. However, I understand that my revocation will not be effective as to uses and / or disclosures: (1) already made in reliance upon this authorization; or (2) needed for an insurer to contest a claim/ policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to