

Olympia Eye Clinic, Inc., P.S.

215 Lilly Road NE; Olympia, WA 98506 • (360) 456-4800 • Fax (360) 456-4812

REQUEST TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____
Date of Birth: _____
Prior Name(s): _____

Purpose of Release (must be indicated to process request)

- Continuity of Care Transfer of Care
 Appointment with other healthcare provider
 Disability/Insurance Application or Claim
 Attorney/Legal Personal
 Other: _____

I request and authorize my information to be released to Olympia Eye Clinic

Information requested from:

Name/Agency: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

This request and authorization applies to:

Medical Abstract. This contains only the medical records needed by you and your providers to provide continuity or transfer of care. This will include recent office visits, comprehensive exams, testing, imaging, and procedure reports, as well as any other records your physician deems necessary to include.

Healthcare information relating to the following treatments, conditions, or dates: _____

Entire Legal Medical Record

Other _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV or AIDS, sexually transmitted diseases, drug and/or alcohol abuse, or psychiatric or psychological conditions.

_____ (initials) I **DO** authorize this information to be released

_____ (initials) I **DO NOT** authorize this information to be released

Printed Name of Patient/Legal Representative: _____

Signature of Patient/Legal Representative: _____

Date: _____ Time: _____ Relationship to patient: _____

This form expires 90 days after the date it is signed unless revoked in writing.

For Staff Use Only: Medical Record # _____ Fulfilled by: _____