Olympia Eye Clinic, Inc., P.S.

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

AUTHORIZATION 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: _____

*Date of appointment if seeing another healthcare provider or transferring care: _____

Most requests will be processed within 10-15 business days. If you have an upcoming appointment with another provider or are transferring care, your records will be sent two weeks prior to that appointment.

I request and authorize Olympia Eye Clinic, Inc., P.S. to release healthcare information on the above-named patient to:

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. If your legal medical record is more than 50 pages and is being sent to anyone other than a healthcare provider, you may be subject to a fee on a per-page basis. If you are subject to a fee, we will inform you before processing your request. You or the person receiving your records will be provided the opportunity to agree to the fees or amend your request at that time.

☐ 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: _____