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: _____

*Date of appointment if transferring care: _____

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

Information requested from:

Name/Agency: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Information to be sent:

☐ 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: _____

_____

☐ All Records

☐ 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: _____

Form must be completely filled out, signed, and dated to be fulfilled.

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

For Staff Use Only: Medical Record # _____Fulfilled by: _____ On Date: _____