



8160 Freedom Lane NE | Suite D | Lacey, WA 98516

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Mailing Address: \_\_\_\_\_

Patient Phone: (\_\_\_\_) \_\_\_\_\_ Previous Name (if applicable): \_\_\_\_\_

I hereby request and authorize the following release of information:

Information to be released BY: Organization / Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Information to be released to
ROUSE EyeCARE CENTER
8160 Freedom Lane NE, Suite D
Lacey, WA 98516
(360) 455-4425

INFORMATION TO BE RELEASED: [ ] All [ ] Date(s) or date range: \_\_\_\_\_

All records include the following information from my records release (patient please initial): I understand that my records may contain information regarding the following sensitive diagnosis or treatment. If the item is initialed, then I give my specific authorization for these records to be released.

\_\_\_\_\_ Drug/Alcohol abuse diagnosis/treatment \_\_\_\_\_ Sexually transmitted Diseases
\_\_\_\_\_ HIV/AIDS testing/diagnosis/treatment \_\_\_\_\_ Mental Illness/Psychiatric diagnosis/treatment

Purpose of Disclosure:

[ ] Patient's Request [ ] Continuing Care [ ] Legal [ ] Insurance [ ] Transfer of Care

[ ] Other (explain): \_\_\_\_\_

This Release expires on the following date or when the following event occurs:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ OR Event: \_\_\_\_\_

MY RIGHTS

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form in order to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by ROUSE EyeCARE CENTER based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: Fill out a revocation form. The form is available from ROUSE EyeCARE CENTER Medical Records; or Write a letter to ROUSE EyeCARE CENTER, Attention: Privacy Officer, 8160 Freedom Lane NE, Suite D Lacey, WA 98516. Once ROUSE EyeCARE CENTER discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

X
Signature: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_
Date: \_\_\_\_\_

Personal representative's Name: \_\_\_\_\_

Relationship to Patient: [ ] Parent [ ] Legal Guardian\* [ ] Power of Attorney for Healthcare\*

\*Attach legal documentation if you are a personal representative other than parent.