MEDICAL RECORDS RELEASE

Patient Name: ___ _____ Date of Birth_____

.

RECORDS BEING REQUESTED FROM:

Name/Organization _____
Address _____
City, State, Zip _____
Phone _____
Fax _____

RECORDS BEING RELEASED TO:

Dr. Joseph Day, East Main Vision Clinic
2732 East Main Ave.
Puyallup, WA 98372
Phone 253-770-2732
PLEASE FAX RECORDS TO 253-770-1023

INFORMATION REQUESTED

__ **Copy of medical records**
__ **Copy of contact lens prescription**
__ **Copy of spectacle lens prescription**
__ **Vision information required by Department of Licensing**
__ **Pertinent vision information for school activities**
__ **Health information regarding work related injuries**
__ **Health information required by non-health-plan ins policy (e.g., accident, disability, liability, or auto ins)**
__ **Other (specify) _____**

PURPOSE OF INFORMATION REQUESTED

__ **At my request**
__ **To provide information to Department of Licensing**
__ **To provide information to school**
__ **To support claims and/or provide reports regarding work-related injuries**
__ **To support claims and/or provide reports regarding activities covered under non-health-plan ins policy (e.g., accident, disability, liability, or automobile ins)**
__ **Other (specify) _____**
_____

EXPIRATION DATE *(90 days from below signature date unless otherwise specified):*

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send a written or electronic note to this office telling us that your authorization is revoked.

When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian)