KAREN WINCHESTER, M.D., P.C.
d/b/a EYE CARE NORTHWEST

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS: CONTINUITY OF CARE

PATIENT NAME_____

PHONE NUMBER_____**DATE OF BIRTH:**_____

I hereby authorize Karen Winchester, M.D., P.C. to release my medical records to:

_____Fax#_____

I understand additional laws require specific consent if my medical record contains any of the information listed below and that by initialing on the line corresponding to the record type, I agree to have these types of records released, if they exist.

_____Mental Health Information _____Genetic Testing Information

_____HIV/AIDS Information _____Drug /Alcohol Diagnosis, treatment or Referral

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. However, I also that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

Refusal to sign this authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health care services is if the health services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time. If you revoke the authorization, the information described above ma no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

I have read this authorization and understand it.

_____ _____

Signature of Patient or Legal Representative Relationship to Patient

Date_____

Unless revoked, this authorization expires in 24 months or shall remain in effect for a period of time reasonably needed to effect the purpose for which it was made.