SUMNICHT
EYE CARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone number: (Home) _____ Phone number: (Mobile)_____

Please Note: Copy fee may be charged for medical records

Above listed patient authorizes the following health care facility to make record disclosure:

Facility Name: SUMNICHT EYE CARE

Facility Address: 21827 76TH AVE W #102, EDMONDS, WA 98026

Facility Phone #: 425-778-2500 **Facility Fax** #: 425-778-5600

Information to be disclosed:
[ ] Last 3 chart notes
[ ] Last 2 years of chart notes
[ ] All medical records
[ ] Dates of Service (Other):_____

The Purpose of Disclosure is:
[ ] Change of Insurance or Physician
[ ] Transfer of Care
[ ] Referral
[ ] Other: _____

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

Phone number: _____ Fax number: _____

Method of Disclosure: [ ] Please mail records [ ] Please fax records

RESTRICTIONS: Only medical records originated through this health care facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed.

I have read the above foregoing Authorization for Release of Protected Health Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____
Signature of Patient/ Parent/ Guardian or Authorized Representative Date

_____ _____
Printed Name of Authorized Representative Relationship/ Capacity to Patient