Authorization to Release or Obtain Health Care Information

Roosevelt Vision Source
9706 4th Ave NE Suite 100, Seattle, WA 98115
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Shawna Williams, Privacy Official

PATIENT NAME: ________________________________DOB: ____________________

PATIENT PHONE NUMBER: ____

ARE MEDICAL RECORDS UNDER ANOTHER NAME? ___________________________________

I authorize information to be released by:

____ Phone #:_____________________
(Name of person/place records are requested from) Fax:_________________________

I authorize information to be released to:

____ Phone #:_____________________
(Name of person/place records are to be sent to) Fax:_________________________

Type of medical records requested:

Last exam chart notes
Records from time period ___________________ to ________________________

By signing below, you authorize your health information to be disclosed including, if applicable, information about substance abuse, mental health conditions, and HIV infections or AIDS. The recipient may re-disclose the information as outlines in HIPPA laws.

You make revoke this authorization at any time by contacting in writing, FAX, or email the Privacy Official as noted in the Notice of Privacy Practices.

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

____ ____________________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

____ ____________________________
Representative Relationship to Patient