



## AUTHORIZATION TO RELEASE HEALTH INFORMATION

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

INFORMATION TO BE  
RELEASED BY:

Children's Eye Care, PLLC  
11800 NE 128th Street Suite 430 Kirkland, WA 98034  
425-823-3937 phone 425-823-7479 fax

INFORMATION TO BE RELEASED TO:

Name \_\_\_\_\_ Organization \_\_\_\_\_

☐ Mail to: Address \_\_\_\_\_

☐ Fax to: \_\_\_\_\_

☐ I will personally pick up the records

Information to be released:

☐ Most recent examination notes

☐ Treatment dates from \_\_\_\_\_ to \_\_\_\_\_

☐ All records

I understand my consent is required to release any health care information related to testing, diagnosis and/or treatment for HIV, sexually transmitted diseases, psychiatric disorders, drug and alcohol use. If I have been tested, diagnosed, or treated for any such conditions, Children's Eye Care is authorized to release all health care information related to such testing, diagnosis or treatment. **Once protected healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect the information.**

THIS AUTHORIZATION EXPIRES IN 90 DAYS FROM THE DATE IT IS SIGNED

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of person requesting records: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Please allow up to 72 hours to process.

### STAFF ONLY

Processed by: Initials \_\_\_\_\_ Date: \_\_\_\_\_ FAX MAIL PICK UP