AUTHORIZATION FOR RECORDS RELEASE

Patient Name____ Date__________________________

Last 4-Digits of Social Security Number________________

Patient Phone Number_______________________________

I hereby authorize Vision Care Center to release my health records under the following terms and conditions:

1)Description of the information to be released:
_____ All information contained in the patient's file, including copies of medical records and copies of records received from any other person or firm with respect to the exam, treatment and care.
_____ Other: ____

2) To whom the information may be released to:

Name:_______________________________________

Address: ______________________________________

City/State/Zip: ______________________________________

Phone Number: _________________Fax: _________________

3) Purpose of the release: ____

4) Date of request: ___________________________________

According to the nationwide standard for privacy regulations regarding personal medical health information (commonly referred to as HIPAA), we at Vision Care Center respect our legal obligation to keep your health information that identifies you confidential. However, once Vision Care Center discloses health information as provided in this authorization request, the recipient may re-disclose the information and may no longer be protected under HIPAA.

I have read and understand this form. I authorize the disclosure of my health information as described in this form. This authorization is valid for 90 days unless revoked in writing. I also have the right to revoke my authorization at any time and upon written notification.

Signature: ____ Date__________________________
Patient / Guardian / Legal Representative

Relationship to Patient: ______________________________

Vision Care Center * Nery C. Sison, O.D.
14700 NE 8th St., Suite 105, Bellevue, WA 98007-4115
Phone 425.746.2122 Fax **425-746-1588**