AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name_____ **Date of Birth**_____

Address _____ **City/State** _____

Zip Code _____ **Telephone Number** _____

I request and authorize:

Pacific Northwest Retina

Tel (206) 215– 3850 ▪ Fax (206) 215-3870

PLEASE OBTAIN INFORMATION FROM:	**PLEASE SEND INFORMATION TO:**
_____ **Name of Provider/Clinic/ Organization**	_____ **Name of Provider/Clinic/ Organization**
_____ **Street Address**	_____ **Street Address**
_____ **City/State/Zip Code**	_____ **City/State/Zip Code**
_____ **Phone Number** _____ **Fax Number**	_____ **Phone Number** _____ **Fax Number**

I AUTHORIZE the following information to be disclosed: (Please INITIAL all that apply)

_____ **Entire Record** _____ **Billing Record** _____ **STD Record**

_____ **Psychiatric/Mental Health** _____ **Alcohol/Substance Abuse** _____ **HIV/AIDS Record**

_____ **Date (s)**_____ _____ **Other**_____

REASON for disclosure of health information: (Please INITIAL)

_____ **At my request** _____ **Continuing care** _____ **Other**_____

ADDITIONAL PATIENT INFORMATION:
I give my specific authorization for these records to be released. In return for releasing these records in response to my request, I release you and your staff from all legal responsibility or liability that may arise from the release of this information. I may revoke this consent at any time in writing, except that revocation will not affect any releases of records which have taken place prior to receipt of revocation.

This authorization to release records expires **90 days** from date signed. Further release of this information to other parties may not be done without further authorization from me.

_____ _____

Patient or legally authorized individual signature **Date**

FOR OFFICE USE ONLY

_____ _____

Records Released by (employee) **Date Information was released**

_____ **Faxed** _____ **Mailed** _____ **Other** _____

Initial **Initial** **Initial**