Authorization for Release of Personal Health Information

Tacoma
3602 S. 19th Street
Tacoma, WA 98405
Ph: 253-759-5555
Fax: 253-759-2123

I authorize the disclosure of information from my records:

Patient Name | Date of Birth

Address

City | State | Zip | Phone

You may OBTAIN my health records FROM:

Clinic/Hospital | Provider Name

Address

City | State | Zip

Fax | Phone

You may SEND my health records TO:

Name (i.e. Self, Provider, Medical Facility)

Address

City | State | Zip

Fax | Phone

Release Criteria

→Type of Information Requested: (check all that apply)

If this section is not completed, responses to record requests will only contain the most recent date of service.

- ☐ Office Visit Notes
- ☐ Visual Fields
- ☐ Imaging
- ☐ Specific Dates of Treatment (must include): ______
- ☐ Operative Reports
- ☐ Other: ______

→ Purpose for Which Information is Being Released: (check one)

- ☐ Sharing Care
- ☐ Transferring Care
- ☐ My Own Records
- ☐ Insurance Claim
- ☐ Legal
- ☐ Other: ______

→Release Authorization Date of Expiration: ______

This authorization for disclosure of medical records expires 90 days from the date signed unless otherwise specified above.

Agreement

*I understand I do not have to sign this authorization in order to obtain medical treatment.

*This authroization may be revoked at any time in writing. If I did, it would not affect any actions already taken by PNWEA based upon this authorization. I may not be able to revoke this authorization if this purpose was to obtain insurance.

*I understand that my records may contain information regarding diagnosis and treatment of HIV, AIDS, or STD's (wheather testing indicated postive or negative results), drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I release PNWEA from all liability related to the transfer of this information.
*Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

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Sending Pacific Northwest Eye Associates Records:
Mail Records to: 3602 S. 19th St Tacoma, WA 98405
Fax Records to: 253-759-2123

Pacific Northwest Eye Associates keeps a record of healthcare services provided to you. You may request a copy of your records. Your records will not be released to others unless directed by you or compelled by law to do so.

Due to time and cost involved in reproducing the entirety of your medical records, should you wish to order them you will be charged at the following rates:

Last Exam Note:	**No Charge; does not include any visual fields or imaging performed on this date.**
Visual Fields/Imaging	**$1.00+Tax per page**
Additional Exam Notes	**$1.00+Tax per page**

There is no charge for sending your medical records to another medical provider or facility.

Please initial below to request your records:

_________ I wish to have my last exam note copied at no cost.

_________ I wish to have my requested date range of records specified on the front of this authorization copied at the above cost structure.

Please allow up to 14 business days to process and complete your request.

Signature

Printed Name if Signed on Benhalf of Patient

Date

Relationship