Authorization to Release Health Care Information FROM Sound Eye and Laser

Patient's Name______________________________ Date of Birth:______________________
Previous Name (if any):_______________________ Daytime Telephone (__) ______________
I request and authorize Sound Eye and Laser, P.S. (choose office):

Nordstrom Medical Tower	Highline Medical Park
1229 Madison St. Suite 1250	16110 8th Ave S.W. Suite B-2
Seattle, WA 98104	Burien, WA 98166
(206) 622-2020	(206) 248-6151
Fax: (206) 223-1963	Fax: (206) 248-4355

To release medical records to the following organization:
Name:____
Address:____ Suite #__________________________
City/State:____
Contact Numbers: Home: _______________________Cell: _____________________________

Type of records requested: (charges for copies of records may be associated with your request)	
Health care information related to the following treatment or condition: ______________________ _____________________________________ _____________________________________ All health care information Other:______________________________	Sensitive Records require specific patient authorization. Please initial the appropriate records requested: ____ Drug and/or Alcohol Abuse ____ Mental Health (may include Pain Management or Psychiatry records) ____ Sexually Transmitted Diseases (incl. AIDS/HIV)

Purpose or Need for this Information:
Continuing Care Copies for Own Use Other:_________________________________

If you request records for your own use there is a fee for copying and handling of your medical records. Washington State Department of Health has established the fee as follows: $1.02 per page for the first 30 pages and $0.78 per page thereafter. A $23 clerical searching and handling fee may be charged to institutions, but not to patients or those making healthcare decisions for them. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Sound Eye and Laser has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization.

____ __________________
Signature of Patient or Legally Responsible Party Date
________________________________ (Authority to sign, if not Patient)

THIS AUTHORIZTION EXPIRES 90 DAYS AFTER DATE SIGNED

For Office Use Only:
Received ____________ (date) ________ (staff initials) Physician _________________
Completed ___________ (date) ________ (staff initials) Administrator ______________