CASCADE
Eye & Skin Centers, P.C.

Authorization To Release Health Care Information

RETURN FAX TO: 253-201-5915

RECORDS DATED PRIOR TO 2009 MAY BE SUBJECT TO AVAILABILITY

SECTION A: MY AUTHORIZATION

Patient Name			**Date Of Birth**
TO	**Doctor / Facility**		
	Mailing Address		
	Email Address		
FROM	**Doctor / Facility**		
	Address		
	City / State / Zip		
Purpose of Disclosure (CHECK ONE)		❑ CONTINUATION OF CARE	❑ PERSONAL
Information to be released			
Department (CHECK ONE)		❑ EYE ❑ SKIN ❑ BOTH	

During your exam we ask questions that are sensitive in nature, due to that and your answers being a part of your medical record- we must make you aware that your answers will be released along with your medical record request.
Patient or patient authorized representative to initial below.

• Sexually transmitted diseases • Psychiatric disorders/mental health	• HIV (AIDS virus) • Drug and / or alcohol use	**PATIENT INITIALS:**

Choose an expiration date for this authorization (CHECK ONE)

❑ On (date): ❑ 365 days from date of signing ❑ When the following event occurs:

SECTION B: MY RIGHTS

1. This authorization will be honored as written. A health care provider will sign off on this request as promptly as required under the circumstances, but no later than fifteen (15) working days. (RCW 70.02.080)

2. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

To take part in a research study **or**

To receive health care when the purpose is to create health care information for a third party.

3. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Cascade Eye and Skin Centers, P.C. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

Fill out a revocation form. A form is available from Cascade Eye and Skin Centers, P.C. **or**
Write a letter to Cascade Eye and Skin Centers, P.C.

4. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature of Patient or Patient's Authorized Representative

Date Time

Print name and relationship if signed on behalf of the patient