Authorization to Release Health Care Information **FAX 253-572-9329**

CASCADE Eye & Skin Centers, P.C.

Section A: My Authorization

Patient Name:			**Medical Record # (office use only)**		
Address:			**Date of Birth:**		
Information to be released by:	Facility Name:		Phone # / Fax #		
	Address:				
	City / State / Zip:				
Information to be released to:	Facility Name:		Phone # / Fax #		
	Address:				
	City / State / Zip:				

Purpose of Disclosure:

List specific description of information to be released:				
Or specific dates of service:		Eye	Skin	Both

Information regarding the following <u>cannot be released</u> without your specific authorization. Please initial all that may be included when your records are released:

Information regarding:		HIV (AIDS virus)		Sexually transmitted diseases
	Psychiatric disorders/mental health			Drug and/or alcohol use

***REQUIRED: This authorization expires:**

	On (date):_____		365 days from the date signed
	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 **<u>or</u>**

   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. **<u>or</u>**

   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