

Authorization to Release Health Care Information



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 cannot be released without your specific authorization. Please check all that may be included when your records are released:

Information regarding:	<input type="checkbox"/> HIV (AIDS virus)	<input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> Psychiatric disorders/mental health	<input type="checkbox"/>	<input type="checkbox"/> Drug and/or alcohol use

*REQUIRED: This authorization expires:

On (date): _____	90 days from the date signed
When the following event occurs: _____	

Section B: My Rights

- 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)
- 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.
- 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.
- 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