Northwest Eye Care Professionals

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Authorization to release Medical Information:

Last Name:_____ First:_____ MI:_____

DOB: _____ Phone number: _____

Address:_____ State_____ Zip code:_____

At my request, I authorize:	**To make disclosure to:**
Practice name:_____	*Practice name*:_____
Address:_____ _____	*Address*:_____ _____
Phone:_____ Fax:_____	Phone:_____ Fax:_____

Specifically, I authorize the use or disclosure of the following information: (please initial)

____ Complete record ___ VT chart notes
____ Chart notes ___ Other _____
____ Diagnostic Records ___ Other _____
Please list specific dates:_____ or **All records** _____

If my records contain the following information, it is also released if CHECKED in boxes below:

HIV/AIDS information Mental health information Genetic testing information Drug/Alcohol information

Statement of understanding:

- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.
- I understand and acknowledge that this authorization extends to use and/or disclosure from my medical records which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS, and/or may include results of an HIV test or the fact that an HIV test was performed.
- You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.
- This authorization is valid for 180 days, unless otherwise revoked by written notice. This does not apply to information already used or disclosed in response to this authorization.
- You may inspect or copy the protected health information to be disclosed or used under this authorization.

Signature of Patient/Personal Representative: _____

Relationship to Patient: _____ Date: _____