Clearwater Family Eye Care

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After January 31, 2024 Submit Release Requests to DrBelinda2004@gmail.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date:_____

Patient Name:_____ Date of Birth:_____

Patient Cell Phone: _____ Patient Email:_____

□Authorization to Transfer my Records *from Clearwater Family Eye Care To:*

I request Clearwater Family Eye Care To Transfer My Health Care Information To The Following Eye Clinic:

Name _____
Address_____
City/State/Zip_____
Phone_____Fax_____

I am requesting release of the following records:

□***All Clinical Records*** □***Clinical Records only related to _____***
□***Current Glasses Prescription*** □***Current Contact Lens Prescription***
□***Current Glasses Prescription*** □***Retinal Imaging***
□ ***Fundus Photographs*** □ ***Visual Fields***

This authorization is limited to the following dates: From:_____To:_____

I give my authorization to use or disclose information regarding testing, diagnosis and treatment for: (disclose pertinent information only as indicated):

□*HIV (AIDS)* □*Sexually Transmitted Diseases*
□*Drug or Alcohol Use* □*Psychiatric/ Mental Health Disorders*

☐ ***I will pick up my records in 10 business days after authorizing my request from the Clinic.***

☐ ***I would like my records faxed to the clinic location designated above.***

☐ ***I have designated and granted permission for another individual other than myself to pick up my records at the Clearwater Family Eye Care Clinic. This name of this individual is _____ and their relationship to me is_____.***

This authorization may be revoked at any time. If revoked, no actions already taken by Clearwater Family Eye Care, based upon this authorization will be affected. I understand that once my protected health information is disclosed, the entity which receives it may re-disclose it, and privacy laws may no longer protect it. Unless the revoked earlier this authorization will expire 90 days after the date it is signed for shall remain in effect for the period reasonably needed to complete the request. In accordance with Washington State and United States Federal Laws & Regulations {WAC 246-08-400, RCW 70.02.005-70.02.905}, research, handling, and processing fees may apply. In accordance within these same regulations, 15 business days must be permitted to complete your requests.

_____ _____

Patient/Guardian Signature ***Date***