Silver Lake Eye Clinic
10217 19th Ave. SE, Suite 102
Everett, WA 98208
Phone (425) 316-9400 Fax (425) 316-8820

Authorization for Release of Protected Health Information

Patient's full name at the time of treatment: ____________________

Date of Birth: ____________________ Social Security Number: ____________________

Date(s) of Treatment: ____________________

Purpose of release: ____________________

I authorize the release of the following records (specify): ____________________

Entity Providing Information: ____________________

Person or Entity Receiving Information: ____________________

Mail Records ____________________

I will Pick-Up Records ____________________

Fax Records to: ____________________

1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable disease, this information will be released as part of my record.
2. I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3. I understand that I may revoke this authorization at any time, but the revocation will not apply to the information that has already been released. Revocations should be sent to any address noted at the top of this form.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5. I understand that there may be a charge for obtaining the requested information.
6. I understand that this authorization will expire 90 days after the dated signed unless specified otherwise.

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Signature of patient or authorized person Date

____

Relationship to patient

PROVIDER USE ONLY:
Date Records Sent: ____________________ Copy to: ____________________