Eyecare Center of Snohomish
415 Avenue D
Snohomish, Washington 98290
Ph. 360-568-6666
Fax. 360-568-1221

Member
American Optometric Association

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Patient number _____

Patient address _____

Patient phone number _____

The Notice of Privacy Practices describes the uses and disclosures of patient health information that may be made without your authorization or consent. This authorization may be used for those specific uses and disclosures of information that require further authorization from you.

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
   - ☐ All (no restriction)
   - ☐ Describe Information _____

_____

_____

2. To whom the information may be released (name(s) or class(es) of recipients):
   - ☐ All (no restriction)
   - ☐ Recipients (List) _____

_____

_____

3. The purpose(s) for the release (it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
   - ☐ At request of patient
   - ☐ Marketing activities
   - ☐ Other (describe) _____

_____

_____

(over)

4. Expiration date _____ or event relating to the individual or purpose for the release: _____

It is completely your decision whether or not to sign this authorization form. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

If you are authorizing us to use your health information for marketing activities, please be advised that we may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____

Print Name: _____

Source of Authority: _____