Washington Pacific Eye Associates
134 Central Way, Kirkland WA, 98033
Phone: 425.889.2020 Fax: 425.739.0601

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Washington Pacific Eye Associates
134 Central Way
Kirkland, WA 98033
Ph: 425.889.2020 Fax: 425.739.0601

This request and authorization applies to:

× Healthcare information relating to the following treatment, condition, or dates: _____

_____

× All healthcare information

× Other: _____

_____

I understand that this authorization is voluntary and that I may cancel this consent to release information to/from WPEA at any time by sending a written notice to:

Washinton Pacific Eye Associates
134 Central Way
Kirkland, WA 98033

I understand that any release that was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential of unauthorized re-disclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Washington Pacific Eye Associates.
I understand that WPEA and its partner may not require completion of this form as a condition of treatment.

Patient Signature: _____ Date Signed: _____

Responsible Guardian: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER THE DATE SIGNED