Northwest Vision Clinic Records Release

2201 NW Market Street | Seattle, WA 98107 | p.206.789.7417 | f.206-789.7651

I, _____ authorize Northwest Vision Clinic to photocopy & disclose my medical records to:

Dr/Office: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

I have been informed that this office will not release my information about me to any person or agency without my consent. I have read the above and have been advised of my right to receive a true copy of this authorization. Further, I understand the contents of this written authorization in its entirety.

I understand that my express consent is required to release any health care information relating to testing for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for any of the previously mentioned conditions, you are specifically authorized to release all health care information related to such diagnosis, testing, or treatment.

_____ _____

Signature of patient or authorized representative Date

Patient's Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Date of Birth: _____ SS#_____

This authorization expires 90 days after date it is signed.