

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Zip Code \_\_\_\_\_ Telephone Number \_\_\_\_\_

I request and authorize:

**Vitreoretinal Associates of Washington**  
Tel (206) 215- 3850 ■ Fax (206) 215-3870

PLEASE <u>OBTAIN</u> INFORMATION <u>FROM</u> :	PLEASE <u>SEND</u> INFORMATION <u>TO</u> :
_____ Name of Provider/Clinic/ Organization	_____ Name of Provider/Clinic/ Organization
_____ Street Address	_____ Street Address
_____ City/State/Zip Code	_____ City/State/Zip Code
_____ Phone Number	_____ Phone Number
_____ Fax Number	_____ Fax Number

I AUTHORIZE the following information to be disclosed: (Please INITIAL all that apply)

\_\_\_\_\_ Entire Record                      \_\_\_\_\_ Billing Record                      \_\_\_\_\_ STD Record  
\_\_\_\_\_ Psychiatric/Mental Health                      \_\_\_\_\_ Alcohol/Substance Abuse                      \_\_\_\_\_ HIV/AIDS Record  
\_\_\_\_\_ Date (s) \_\_\_\_\_                      \_\_\_\_\_ Other \_\_\_\_\_

REASON for disclosure of health information: ( Please INITIAL)

\_\_\_\_\_ At my request                      \_\_\_\_\_ Continuing care                      \_\_\_\_\_ Other \_\_\_\_\_

ADDITIONAL PATIENT INFORMATION:

I give my specific authorization for these records to be released. In return for releasing these records in response to my request, I release you and your staff from all legal responsibility or liability that may arise from the release of this information. I may revoke this consent at any time in writing, except that revocation will not affect any releases of records which have taken place prior to receipt of revocation.

This authorization to release records expires **90 days** from date signed. Further release of this information to other parties may not be done without further authorization from me.

\_\_\_\_\_  
Patient or legally authorized individual signature                      Date

FOR OFFICE USE ONLY

_____ Records Released by (employee)	_____ Date Information was released	
_____ Faxed Initial	_____ Mailed Initial	_____ Other Initial