CHILDREN'S EYE CARE
The art and science of vision.
Part of the Mednax® Family

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

INFORMATION TO BE RELEASED BY:

Children's Eye Care, PLLC
11800 NE 128th Street Suite 430 Kirkland, WA 98034
425-823-3937 phone 425-823-7479 fax

INFORMATION TO BE RELEASED TO:

Name _____ Organization _____

- ☐ Mail to: Address _____
- ☐ Fax to: _____
- ☐ I will personally pick up the records

Information to be released:

- ☐ Most recent examination notes
- ☐ Treatment dates from _____ to _____
- ☐ All records

I understand my consent is required to release any health care information related to testing, diagnosis and/or treatment for HIV, sexually transmitted diseases, psychiatric disorders, drug and alcohol use. If I have been tested, diagnosed, or treated for any such conditions, Children's Eye Care is authorized to release all health care information related to such testing, diagnosis or treatment. **Once protected healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect the information.**

THIS AUTHORIZATION EXPIRES IN 90 DAYS FROM THE DATE IT IS SIGNED

Signature: _____ Date: _____

Name of person requesting records: _____

Relationship to patient: _____

Please allow up to 72 hours to process.

STAFF ONLY

Processed by: Initials _____ Date: _____ FAX MAIL PICK UP