Physicians Eye Clinic and Surgery Center
3930 Hoyt Avenue Everett, Washington 98201
Telephone: 425-259-2020 ▲ Fax: 425-259-2801

Authorization to Use or Disclose My Health Care Information

Patient name: _____ Date of birth:_____

Are medical records filed under another name? _____Phone Number _____

Information to released **BY**:	Information to be released **TO**:
☐ Physicians Eye Clinic	☐ Physicians Eye Clinic
☐ _____ Organization Name	☐ _____ Organization Name
_____ Address	_____ Address
_____ Phone / Fax	_____ Phone / Fax

I. You may use or disclose the following health care information (check all that apply):

☐ All health care information in my medical record.
☐ Health care information in my medical record relating to the following treatment or condition:_____
☐ Health care information in my medical record for the date(s):_____
☐ Other (e.g., X-rays, bills), specify date(s):_____

Reason(s) for this authorization (check all that apply):

☐ At my request ☐ Other (specify)_____

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed.)

☐ in 90 days from the date signed ☐ on (date: mm/dd/yyyy): _____
☐ when the following event occurs: _____
(no longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Physicians Eye Clinic and Surgery Center/Gallery of Eyewear based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form.
- Write a letter to Physicians Eye Clinic and Surgery Center/Gallery of Eyewear.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

There may be a charge for copies of your medical record unless your copies are being sent to another physician or healthcare facility.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)