Authorization for Release of Personal Health Information

Howard S. Barnebey
Ernesto D. Golez
Tel: (425) 454-3937
Fax: (425) 453-6646

I hereby authorize the diclosure of information from my records:

Patient Name	Date of Birth
Address	Phone
Address (ctd.) City	State Zip

You may OBTAIN my health records FROM:

Clinic/Hospital	Provider Name
Address	
City State	Zip
Fax	Phone

You may SEND my health records TO:

Name (i.e. Self, Attorney, Provider)	
Address	
City State	Zip
Fax	Phone

Release Criteria

→ Type of Information Requested: (check all that apply)

If this section is not completed, responses to record requests will contain a record abstract of the two most recent dates of service.

- ☐ Office Visit Notes
- ☐ Visual Fields
- ☐ Imaging (HRT, SDP, OCT, etc.)
- ☐ Operative Reports
- ☐ IOL Measurments
- ☐ Tear Film Imaging
- ☐ Other: _____
- ☐ **Specific Dates of Treatment (must include):** _____

→ Purpose for Which Information is Being Released: (check one)

- ☐ Sharing Care
- ☐ Transferring Care
- ☐ Insurance Claim
- ☐ My Own Records
- ☐ Skilled Nursing Facility Records
- ☐ Legal
- ☐ Other: _____

→ Release Authorization Date of Expiration : _____

This authorization for disclosure of medical records expires 90 days from the date signed unless otherwise specified above.

Agreement

* I understand I do not have to sign this authorization in order to obtain medical treatment.
* This authorization, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for STD's AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions except in limited circumstances such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party.
* This authorization may be revoked at any time, except to the extent that action has been taken in relience on this authorization.
* Any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____
Signature

_____
Date

If Signed by Legal Representative:

_____
Printed Name of Legal Representative

_____
Relationship to Patient

SEE OTHER SIDE >

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SPECIALTY EYECARÈ CENTRE
The accent is on care

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Fax: (425) 453-6646

Sending Specialty Eyecarè Centre Records:

Mail Records to: 1920 116th Ave NE Bellevue, WA 98004
Fax Records to: (425) 453-6646
Email Images to: mreception@specialtyeyecarecentre.com
Note: If emailing color images, use subject line, "IMAGES" and include patient's full name and date of birth in body of email. Do not send other records apart from images to this email. **All other content will be discarded**.

Specialty Eyecarè Centre keeps a record of healthcare services provided to you. You may request a copy of your records. You may also ask to correct that record. Your records will not be released to others unless directed by you or compelled by law to do so.

Due to time and cost involved in reproducing the entirety of your medical records, should you wish to order them you will be charged at the following rates:

Last Exam Note:	* No charge; does not include any imaging, visual fields, or measurments performed on this date.
Imaging/Visual Fields/Measurements:	* $1.00+tax/page
Additional Exam Notes/Operative Reports:	* $1.00+tax/page

For more information on rates set by the State of Washington Uniform Healthcare Information Act RCW 70.02, Section 102 (12), please visit: http://apps.leg.wa.gov

If you do request your records you will be contacted by our office to arrange payment. The authorization is not required to be honored or completed until payment is received.

There is no charge for sending your medical records to another medical provider or facility.

Please initial below to request your records:	
_____	I wish to have my last exam note (excluding imaging, measurements and other testing) copied at no cost.
_____	I wish to have my requested date range of records specified at the front of this authorization copied at the above cost structure.

*Please allow up to 12 business days to process and complete your request.