

AUTHORIZATION FOR RECORDS RELEASE REQUEST



Doctor Name: _____

Practice Name: _____

Address: _____

Phone / Fax Number: _____

Your former patient has consulted Center Vision & Contact Lens Clinic. In order to provide the best possible healthcare, we would like to review the patient's records and history. Thank you in advance for helping us provide continuing quality patient care.

Patient name _____

Date of Birth _____

Last 4-Digits of Social Security Number _____

1. Description of the information to be released:

_____ All information contained in the patient's file, including copies of medical records and copies of records received from any other person or firm with respect to the exam, treatment and care.

_____ Other: _____

2. To whom may the information be released to:

Dr. Gerald F. Berges, O.D., F.A.A.O. Dr. L. Greg Luehrs, O.D., F.A.A.O.

Dr. Aaron M. Banta, O.D. Aaron D. Qunell, O.D.

Clinic Name: Center Vision & Contact Lens Clinic

Address: 4015 West Clearwater Avenue

City/State/Zip: Kennewick, WA 99336

Phone/Fax Number: (509) 783-8383 - Fax: (509) 735-2592

3. Purpose of the release: _____

4. Date of request _____

In April 2003, a new law took affect that created a nationwide standard for protecting personal health information. That law is commonly known as HIPAA. The HIPAA privacy regulations apply to everyone with access to personal medical information. At Center Vision & Contact Lens Clinic, we are committed to treating and using protected health information about you responsibly. We respect our legal obligation to keep health information that identifies you confidential.

I understand that once Center Vision & Contact Lens Clinic discloses health information as provided in the authorization request, the recipient may re-disclose the information and may no longer be protected under HIPAA.

I have read and understand this form. I authorize the disclosure of my health information as described in this form. This authorization is valid for 90 days unless revoked in writing. I also have the right to revoke my authorization at any time and upon written notification.

Signature: _____ Date: _____

(Patient / Guardian / Legal Representative)

Relationship to patient: _____