EYECARE Associates

Rebecca Dale, MD
Brian Duvall, OD
Nathania Nhouyvanisvong, OD
Nessa Livingston, OD
Bryan Redick, OD

Release of Information Authorization

Patient Name: _____

Date of Birth: _____ Patient Phone Number: _____

Name of Doctor to Release Records from: _____

Clinic Name: _____

Clinic Fax Number: _____ Clinic Phone Number: _____

I, _____, hereby authorize the professional office of my doctor listed above to release my health information identifying me:

1.) Detailed description of the information to be released:

_____

2.) To whom may the information be released?

_____

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I understand that this release is valid for a period of one year. I further understand that I may cancel or revoke this authorization at any time in writing.

This authorization is invalid if not signed and dated by the individual requesting the release.

X_____ Date: _____

(Patient or Legally authorized individual)

Please fax the disclose of health information to:

☐ **North Bend Clinic**
126 East 2nd Street
North Bend, WA 98045
Ph #: (425)-831-2020
Fax #: (425)831-0027

☐ **Snoqualmie Ridge Clinic**
7724 Center Blvd SE, Ste. 100
Snoqualmie, WA 98065
Ph #: (425)831-2060
Fax #: (425)831-0028

☐ **Sammamish Clinic**
22620 SE 4th St Ste 110
Sammamish, WA 98074
Ph#:(425)242-6868
Fax#:(425)961-0354