Arbor Eyecare

North Bend | Snoqualmie | Sammamish

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 disclosure of health information to:

Carol Chou, OD
Rebecca Dale, MD
Tyler Nelson, OD
Aleksandra Nowakowska, OD
Mallory Troyer, OD
Jaime Wang, OD

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