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?

☐ Arbor Eyecare
126 E 2nd St
North Bend, WA 98045
Fax: 425-831-0027

☐ _________________________
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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 Stratton, OD
Mallory Troyer, OD
Jaime Wang, OD

(P) 425.831.2020
(F) 425.831.0028

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