VillageEyeCare, LLC

# Records Release
# Instructions & Important Information

Please read all information and instructions before completing and signing this authorization form.

**There may be a charge for postage and copies of your medical record unless your records are being sent to another physician or healthcare facility.**

Many patients ask Village Eye Care, LLC to communicate by fax or email. It is our policy to use fax transmissions when necessary for treatment, payment or healthcare operations. By providing Village Eye Care with a fax telephone number, you are consenting to our use of that number for communicating with you by fax.

We cannot send protected health information through email.

## Patient Rights

You have the right to revoke or cancel this authorization, in writing, at any time.

## Cancellation Notice

According the the Uniform Health Information Act for the State of Washington, records shall be released within fifteen (15) days after receipt of a signed, dated release form. Since records are usually handled within 2-3 business days after receipt, Village Eye Care will not be held responsible for any release of medical information accomplished before receipt of a written notice of cancellation. Revocation takes place from the date of receipt of written request.

## Instructions for Canceling a Request:

- You must provide a written request to us asking for revocation/cancellation of the original release.
- We need to have your complete name, date-of-birth, telephone number (home/work) and the name of the person/agency that you authorized to receive the medical information.
- If the release has already been processed, you will be notified by us. The release will be revoked for any further disclosure.
- If you have any questions concerning the cancellation process, please call us at 360-939-0604.

VillageEyeCare, LLC

# Authorization for the Release of Medical Information

Patient's Name _____ Birth Date _____
LAST FIRST MI

| Records to be Released TO: | Records to be Released FROM: |
|---|---|
| ☐ Village Eye Care OR as indicated below | ☐ Village Eye Care OR as indicated below |
| _____<br>Organization/Person Name | _____<br>Organization/Person Name |
| _____<br>Street Address | _____<br>Street Address |
| _____<br>City, State, Zip | _____<br>City, State, Zip |
| _____<br>Phone FAX | _____<br>Phone FAX |

| Please release the following health information: | The reason for request |
|---|---|
| ☐ All healthcare information in my medical record.<br>☐ Healthcare information relating to the following condition: _____<br>☐ Healthcare information for the following dates: _____<br>☐ Spectacle & Contact Lens Prescriptions, most recent.<br>☐ Retinal Photographs (there may be a $5 fee per photo).<br>☐ Other _____ | ☐ Moving out-of-area<br>☐ Transferring care locally<br>☐ Insurance<br>☐ Legal Review<br>☐ Continuing Care with specialist<br>☐ Other _____ |

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded here: _____.

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits).

**There may be a charge for copies of your medical record unless your copies are being sent to another physician or healthcare facility.**

Authorization will expire in 90 days unless otherwise specified. Other date or event: _____.

_____ _____ _____
Please ***print*** your name Please ***sign*** your name Date

_____ _____
Legal Representative if unable to sign or minor Description of Authority or Relationship

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**Office Use Only** Date request sent/received: _____ Date records provided: _____ Mail FAX In Person