ISSAQUAH eye care

DR. MAI X. NGUYEN & ASSOCIATES
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

MEDICAL RECORD RELEASE

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____

SEND RECORD OUT

I request and authorize Issaquah Eye Care to release information to:

Provider or Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

RECEIVE RECORD

I request and authorize the provider/clinic indicated below to release health information to Issaquah Eye Care:

Provider or Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below or on the following date, event, or condition:

I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____

Patient or Legal Guardian's Signature Date