Kitsap Eye PHYSICIANS

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

SSN: _____ PREVIOUS NAME: _____

I request and authorize:	to release health care information of the patient named above to:
Name: _____	Name: _Kitsap Eye Physicians_____
Address: _____	Address: __2655 Wheaton Way_____
City, State, Zip: _____	City, State, Zip: _Bremerton, WA 98310_____
Phone: _____ Fax: _____	Phone: _360-377-3703_ Fax: 360-373-1688_
	Email: _____

This request and authorization applies to: (check one)

___ Health care information relating to the following treatment/condition

and the dates of treatment: _____

___ All health care information

___ Other: _____

For the purpose of: ___ Concurrent care ___ Transfer of care ___ At my request

I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure had already been made in accordance with this document.
I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.
I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing and treatment.
I understand that once health care information is disclosed, the person or organization that receives it, may re-disclose it, and that it may no longer be protected by privacy laws.

_____ _____
Signature of patient or patient's authorized representative Date

_____
Relationship