pediatrix | EYE CARE OF KIRKLAND

AUTHORIZATION TO REQUEST HEALTH INFORMATION

Patient name: ____________________ Date of birth.: ____________________

INFORMATION REQUESTED BY (PATIENT)

Requestor name: ____________________

Address: ____________________ City: ____________________ ZIP: ____________________

Phone: ____________________ Alt Phone: ____________________ Email: ____________________

PLEASE RETURN REQUESTED INFORMATION TO

Name: ____________________

Address: ____________________ City: ____________________ ZIP: ____________________

Phone: ____________________ Fax: ____________________ Email: ____________________

The following information is requested:

❒ Most Recent examination notes

❒ Treatment dates from ____________________ to ____________________

❒ All records

I understand my consent is required to release any health care information related to testing, diagnosis and/or treatment for HIV, sexually transmitted disease, psychiatric disorders/mental health or drug and alcohol use. If I have been tested, diagnosed or treated for above conditions, Pediatrix Eye Care is specially authorized to release all health care information relating to such testing, diagnosis or treatment.

I understand that once the above information is disclosed, it may be disclosed further by the recipient, and the information may not be protected by federal privacy laws or regulations.

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

Signature:____________________ Date:____________________

Print name of requestor (if other than patient) ____________________

Relationship to patient (if other than patient) ____________________

STAFF ONLY
Processed by: Initials ____________________ Date ____________________ ❒Fax ❒Mail ❒Email