pediatrix | EYE CARE

AUTHORIZATION TO REQUEST HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Information is being **requested from:**

Name_____
Address_____ __
_____
Ph_____ Fx_____

Information to be **Released by:**

Name_____
Address_____
_____
Ph_____ Fx_____

Please return requested information to:

Pediatrix Eye Care
11800 NE 128th St #430, Kirkland, WA 98034 or Fax 425-823-7479

I am requesting the following information:

- ☐ Most recent examination notes
- ☐ Treatment dates from _____ to _____
- ☐ All records

I understand my consent is required to release any health care information relation 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.

Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect the information.

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

SIGNATURE:_____ DATE:_____

Print name of Requestor if not patient: _____

Relationship to patient (if other than patient):_____

STAFF ONLY
Processed by: Initials _____Date _____ FAX MAIL