Seattle Ophthalmology, PLLC

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Medical Records Release

Patient Information

Name _____ Address _____

Birthdate _____ _____

Records to be Released From / To (circle one)

Physician _____ Address _____

Company _____ _____

Phone _____ Fax _____

Information to be Released

- ❑ All Clinic Records
- ❑ Visual Fields / OCTs / Tests
- ❑ Office Notes
- ❑ Eye Records
- ❑ Photographs
- ❑ Other: _____

For all dates of service, unless otherwise specified here: _____

In compliance with state statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

- ❑ Mental Health
- ❑ AIDS test results
- ❑ Drug Abuse
- ❑ Development Disabilities
- ❑ AIDS-related Disease Diagnosis
- ❑ Other: _____
- ❑ Alcoholism

Purpose for Disclosure

- ❑ Further Medical Care
- ❑ Payment of Insurance Claim
- ❑ Legal Investigation
- ❑ Application for Insurance
- ❑ Vocational Rehabilitation Evaluation
- ❑ Personal
- ❑ Disability Determination
- ❑ Other: _____

I understand that this authorization shall be valid for one (1) year unless a sooner date is stated: _____
I further understand that I may always revoke this release through written notice to Medical Records. I authorize the release of my medical records in accordance with the specifications listed above.

_____ _____
Signature of Patient Date Signed

If signed by person other than patient:

Patient's Status ❑ Minor ❑ Incompetent ❑ Disabled ❑ Deceased
Authority ❑ Legal ❑ Legal Guardian ❑ Next of Kin

Relationship to Patient: _____