LIFESTYLE EYE CENTER
Healthy You – Healthy Eyes

1610 Penny Ln
Walla Walla, WA 99362-4477
ph: (509) 540-3937 **fx**: (509) 540-3938
www.LifestyleEye.com

Record Release Authorization

First name _____ **Last Name** _____ **Birthdate** _____

Address _____

City _____ **State** _____ **Zip code** _____

	Authorizes:	**Release Records to:**
Physician	_____	Dr. Arthur Giebel, MD/Dr. Tara Evanger, OD
Health Care Facility	_____	Lifestyle Eye Center
Facility Address	_____	1610 Penny Ln Walla Walla WA 99362-4477

Information to be Released:

☐ All Clinic Records ☐ Visual Fields ☐ Lab Reports
☐ Office Notes ☐ OCT Imaging ☐ Medication List/Latest A1C
☐ Photographs ☐ Image Reports ☐ Other (specify)_____

List other facilities' records to be included when releasing for the purpose of continuing medical care:

_____

For the Following Dates: _____

Purpose or need for disclosure: (check applicable categories)

☐ Further medical care ☐ Payment of insurance claim ☐ Legal
☐ Application for insurance ☐ Vocational rehabilitation evaluation ☐ Personal
☐ Disability determination ☐ Other (specify) _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed above.

April 2003, a new law took effect that created a nationwide standard for protecting personal health information. That law is commonly known as HIPAA. The HIPAA privacy regulations apply to everyone with access to personal medical information.

I understand that the information used of the disclosed may no longer be protected under HIPAA. At Lifestyle Eye Center, we are committed to treating and using protected health information about you responsibly. We respect our legal obligation to keep health information that identifies you confidential and will follow the HIPAA regulations regarding this new requested information.

I have read and understand this form. I authorize the disclosure of my health information as described in this form. This authorization is valid for 90 days unless revoked in writing.

Signature of Patient or Authorized Party: _____ Date: _____

Print Name and Relationship (if not patient):_____