Northwest Vision Clinic Records Request

2201 NW Market Street | Seattle, WA 98107 | p.206.789.7417 | f.206-789.7651

I, _____ authorize the doctor/office below to photocopy and disclose my medical records to Northwest Vision Clinic. I have been informed that this office will not release any information about me to any person or agency without my consent.

Dr/Office: _____

Address: _____

City/State/Zipcode: _____

Phone: _____ Fax: _____

My Personal Information:

Patient's Name: _____

Address: _____

City/State/Zipcode: _____

Phone: _____ Fax: _____

Date of Birth: _____ SS#: _____

I have read the above and also have been advised of my right to receive a true copy of this authorization. Further, I understand the contents of this written authorization in its entirety.

_____ _____

Signature of patient or authorized representative Date

I understand that my express consent is required to release any health care information relating to testing for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of the previously mentioned conditions, you are specifically authorized to release all health care information related to such diagnosis, testing, or treatment.

_____ _____

Signature of patient or authorized representative Date

This authorization expires 90 days after date it is signed.