

**Authorization for Vitreoretinal Associates  
To use or Disclose My Health Care Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SSN \_\_\_\_\_ Previous Name \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Zip Code \_\_\_\_\_ Telephone Number \_\_\_\_\_

I request and authorize: Vitreoretinal Associates  
1221 Madison Street, Suite 1002  
Seattle, WA 98104  
(206) 215-3850 Fax (206) 215-3870

\_\_\_\_\_ To Release PHI and other healthcare information of the aboved-named patient to:

or

\_\_\_\_\_ To Obtain PHI and other healthcare information of the above-named patient from:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax \_\_\_\_\_

You may use or disclose the following health care information (check all that applies):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition: \_\_\_\_\_
- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g., X Rays, Bills), specify date(s): \_\_\_\_\_
- You may use or disclose health care information regarding testing, diagnosis, and treatment for (circle all that apply) :

HIV (AIDS virus)

Psychiatric disorders/mental health

Sexually transmitted diseases

Drug and/or alcohol use

Reason(s) for this authorization (check all that apply):

- At my request
- Other (specify) \_\_\_\_\_
- When the following event occurs: \_\_\_\_\_

I give my specific authorization for these records to be released. In return for releasing these records in response to my request, I release you and your staff from all legal responsibility or liability that may arise from the release of this information. I may revoke this consent at any time in writing, except that revocation will not affect any releases of records which have taken place prior to receipt of revocation.

This authorization to release records expires in 90 days from date signed. Further release of this information to other parties may not be done without further authorization from me.

\_\_\_\_\_  
Patient or legally authorized individual signature

Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

Relationship