

Medical Records Release
(Authorization for Use or Disclosure of Protected Health Information)

(Name of Patient) _____
(Birthdate)

(Street Address) _____
City, State, Zip Code

Authorizes:

Release of records to:

Northwest Pediatric Ophthalmology

(Name of Healthcare Facility)

(Name of Physician)

105 W 8th Ave #512

(Street Address)

(Name of Healthcare Facility)

Spokane, WA

(City, State, Zip Code)

(Street Address)

(509) 838-6686 **(509)343-5115**

(Phone #) (Fax #)

(City, State and Zip code)

(Phone #) (Fax#)

Information to be used, released or shared

- All clinic information
 Only specified information _____

I understand that this authorization shall be valid for 90 days unless otherwise stated below or revoked through written notice to Medical records. _____
(alternate date if not 90 days)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to this office. I understand that a revocation is not effective to the extent that Northwest Pediatric Ophthalmology has already relied on the authorization for use or disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under state and federal law.
- Refuse to sign this authorization.

Signature of Patient/ Parent _____ **Date** _____

(Authorized signature's name) _____
(Relationship)