*We're focused on your child's vision.*

NORTHWEST PEDIATRIC EYE CARE

# Authorization to Disclose Health Care Information

Patient's Name: _____ Date of Birth: _____

Phone Number: _____ Previous Name: _____

**Please <u>obtain</u> information <u>from</u>:**

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____
Phone Fax

**Please <u>send</u> information <u>to</u>:**

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____
Phone Fax

Describe the type of information to be disclosed:

Reason for disclosure of health information: (Please <u>initial</u>):

____ At My request ____Job ____Legal
____Continuing Care ____ School ____Insurance
____Other _____

Additional Patient Information:

- I understand that I have the right to revoke the authorization at any point before it is processed.
- I understand that I do not have to sign this authorization to get treatment.
- I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.
- I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by Northwest Pediatric Eye Care.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

_____ _____
Patient Signature (Legal Guardian, if applicable) Date

2/2009, revised 3/2011

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