Permission for Release of Medical Records

Patient Name: _____ Date of Birth: _____

☐To ☐From Puget Sound Eye Care

Practitioner: ☐Melvin R. Carlson, MD ☐Matthew D. Carlson, OD
☐Curtis A. Ono, OD ☐Stephanie S. Ho, OD

Office: ☐Seattle Office
2501 North 45th Street
Seattle, WA 98103
Phone: 206-526-5222
Fax: 206-675-1460

☐Bellevue Office
1515-116th Ave NE, Suite 104
Bellevue, WA 98004
Phone: 425-454-0200
Fax: 425-454-2345

☐To ☐From Name of Provider: _____

Clinic Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

This information may include:

☐ All health care information whether oral or recorded in any form or medium, that identifies the patient, or can readily be associated with the patient and relates to the patient's care. This will include all healthcare information in your possession whether generated by Puget Sound Eye Care, or any other source. Health care information associated with the drug or alcohol use, mental or psychiatric care, HIV status or diagnosis of AIDS or other sexually transmitted diseases will be included. I understand that my express consent is required to release information in relation to drug or alcohol abuse, mental illness, psychiatric treatment, AIDS and HIV status and sexually transmitted diseases.

☐ ONLY the following: _____

I understand that I have the following rights:

- I do not have to sign this authorization to receive treatment and care at Puget Sound Eye Care.
- I am able to revoke this authorization at any time by filling out a Revocation Form or writing to our practice requesting the revocation of this authorization.

I understand that once health care information is disclosed to another party, Puget Sound Eye Care cannot protect the privacy of the released information. This authorization is effective 90-days from the date of the authorization (date specified below). I understand the contents of this authorization will be charged for copying of the requested medical records as allowed by Washington State law RCW 70.02.080.

☐ I give my permission to ☐FAX ☐EMAIL this information. I am aware that the information that I am requesting to be transferred may contain protected health information. (Initial)_____

Patient or Parent/Legal Guardian Signature: _____
Printed Name: _____
Date: _____
Relationship to Patient: _____