Medical Records Release

(Authorization for Use or Disclosure of Protected Health Information)

(Name of Patient) (Birthdate)

(Street Address) City, State, Zip Code

Authorizes:

Northwest Pediatric Ophthalmology
(Name of Healthcare Facility)

105 W 8th Ave #512
(Street Address)

Spokane, WA
(City, State, Zip Code)

(509) 838-6686 **(509)343-5115**
(Phone #) (Fax #)

Release of records to:

(Name of Physician)

(Name of Healthcare Facility)

(Street Address)

(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)