ISLAND EYE CARE
MEDICAL & SURGICAL EYE CARE

Authorization to Release Medical Records

Please complete this form in it's entirety

In order to comply with federal HIPAA regulations, a written request must be obtained prior to the release of private health information. Once the request is received Island Eye Care will process and distribute records in approximately 15 days.

Patient Name:_____ Date of Birth:_____

Street Address:_____ Phone Number:_____

City/State/Zip Code:_____

Purpose of disclosure:

- □ Personal
- □ Transfer of Eye Care
- □ Primary Care Provider
- □ Insurance
- □ Other:_____

Medical Records to be released from:

Dr. Robert Johnson MD
Island Eye Care
231 SE Barington Dr Ste 208
Oak Harbor, WA 98277
Phone: 360-240-2020
Fax: 360-240-1989

I authorize Island Eye Care to release the following health care information:

□ Summary of all visit/chart notes from date: _____to date:_____

□ All medical records (diagnostic tests included)

□ All health care information in my medical record

□ Health care information in my record relating to the following treatment or condition:_____

□ Other:_____

Health Care Information to be released to:

Facility Name:_____ Doctor Name:_____

Facility Address:_____ City/State/Zip Code:_____

Phone Number:_____ Fax Number:_____

This authorization will expire 90 days after date signed.

I hereby authorize Dr. Robert Johnson / Island Eye Care to release my health information. I understand that I may revoke this request at any time in writing, but it will not effect any information released prior to my notification of cancellation.

_____ _____
Printed name of patient Date

_____ _____
Signature of patient or legally authorized representative Date