Silver Lake Eye Clinic 10217 19th Ave. SE, Suite 102 Everett, WA 98208

Phone (425) 316-9400 Fax (425) 316-8820

Authorization for Release of Protected Health Information

Date of Birth: Social Security Number:		er:	
Date(s) of Treatment:			
Purpose of release:			
authorize the release of the following	ing records (specify):		
Entity Providing Information:	Person or Entity	Person or Entity Receiving Information:	
Mail Records	I will Pick-Up Records	Fax Records to:	
 I understand that if the person or en this information will no longer be p I understand that I may revoke this that has already been released. Revolution I understand that I may refuse to sign obtain treatment. I understand that there may be a characteristic of the person or entries. 	tain documentation of alcohol abuse, psycation will be released as part of my recorditity receiving this information is not coverotected and may be re-disclosed. authorization at any time, but the revocat ocations should be sent to any address not generate the authorization and that my refusal the targe for obtaining the requested information will expire 90 days after the dated signed	d. ered by federal privacy regulations, tion will not apply to the information oted at the top of this form. to sign will not affect my ability to ion.	
Signature of patient or authorized person		Date	

Copy to:_____

Date Records Sent: