# Washington Eye Physicians Surgeons
# Medical Records Release Form

**PATIENT INFORMATION**

Name: _____

Date of Birth: _____

Current Address: _____

_____

E-mail: _____

Phone:

**SEND INFORMATION TO**

☐ Myself at the address above

Provider/Organization: _____

Address: _____

_____

Phone: _____

Fax:

| **INFO TO BE DISCLOSED:** | **FORMAT OF INFORMATION TO BE DISCLOSED:** |
|---|---|
| _____# of Past Visits | ☐ Paper |
| _____# of Years | ☐ Email (pdf format) |
| ☐ Other: | Email Address: |

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Washington Eye Physicians & Surgeons. Any revocation will not apply to information that has already been released in response to this authorization. After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

Signature of Patient or Representati Date

Print Name Relationship to Patient*

*If not signed by patient or parent of a minor, authorizing documentation is required.

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