Eye Doctors of Washington
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Please, check location where you are requesting records from)

___ 2 Wisconsin Circle	**___ 4600 North Park Avenue**	**___8230 Boone Boulevard**	**___1016 16th Street NW**
Suite 230	**Plaza North**	**Suite 125**	**Lower Level**
Chevy Chase, MD 20815	**Chevy Chase, MD 20815**	**Vienna, VA 22182**	**Washington,DC 20036**
Ph: 301-215-7100	**Ph:240-855-0720**	**Ph:703-962-7104**	**Ph:202-659-2050**
Fax: 240-482-3070	**Fx: 301-215-4144**	**Fx: 703-883-0222**	**Fx: 202-452-1415**

_____
Print Patients Full Name

_____ / _____ / _____
Birth Date (mm/dd/yyyy)

_____
Street Address

_____
Social Security Number

_____
City, State, ZIP Code

_____
Phone (Home)

I _____, do hereby authorize _____ to release:
(Patients Name) (Name of Facility)

DATES OF SERVICE _____

____ ENTIRE MEDICAL RECORD **_____ LASIK** **_____ EKG**

____ OFFICE NOTES **_____ CATARACT** **_____ LABS**

_____CONSULTATION NOTES **_____ OTHER (Specify)** **_____LAST 2 YEARS**

_____ I do _____ I do not Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO: _____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, State, ZIP Code

_____
Phone Number

PURPOSE OF DISCLOSURE: _____

_____

Please provide current telephone number in the event we need to contact you: _____
May we leave a message at the number provided: Yes _____ No _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation.

I understand that the information used or disclosed may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorized the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____ / _____ / _____
Signature of individual or guardian or Personal Representative of patient's estate Date

Mode of delivery: _____ Mailed _____ Email

EMAIL ADDRESS_____ ROI SPECIALIST_____

NOTE: There is a charge for copying records. Healthport has been contracted to provide this service and will invoice you directly. Maryland State Rates apply $0.76 per page, plus first class postage. HEALTHPORT CUSTOMER SERVICE 1-800-367-1500