Eyes Doctors of Washington
2 Wisconsin Avenue
Chevy Chase, Maryland 20815
Phone 301-215-7100
Fax 301-215-4144

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ / _____ / _____
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 — email

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 a personal copy of your 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