




AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Complete all sections of form for release of medical records. * = required information.

Name of Patient:* _____ Soc. Security #: _____ - _____ - _____ or last 4 digits _____
Address:* _____ Phone Number:* _____
City, ST ZIP* _____ Date of Birth:* _____ / _____ / _____

1. Type of Request: I hereby request that: Provide the following PHI and process it thru:

 Eye Doctors of Washington Attn: Medical Records Requests 2 Wisconsin Circle, Suite 200 Chevy Chase, MD 20815 Phone: (301) 215-7100 Fax: (301) 215-4144 www.edow.com	 Eye Doctors of Washington Attn: Medical Records Requests 1016 16 th St. NW, Lower Level Washington, DC 20036 Phone: (202) 659-2050 Fax: (202) 452-1415 www.edow.com	 universata 12800 Middlebrook Road, Suite 400 Germantown, MD 20874 Phone: 301-916-4700 Fax: 301-916-8776 www.universata.com
---	---	--

or any other such person as they may authorize, and permit them to examine, copy or reproduce, in any manner, any and all portions desired by them of the following:

2. Reason for Release: (Check) ___ Personal Copy ___ Transfer to New Doctor ___ Move ___ Attorney/Legal ___ Insurance

3. Include PHI Date Range to be Released (include date range, all dates, date of service, etc.) _____

4. Description of PHI to be Released: (Check ALL that apply)

<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Office Notes	<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/>
<input type="checkbox"/> Consultation Notes or Letters	<input type="checkbox"/> LASIK	<input type="checkbox"/> Other (Specify) _____

5. If Applicable, Please Check Specific Confidential PHI Authorized for This Release Listed Below:

By signing my initials next to the specific category of highly confidential PHI, I am authorizing **Eye Doctors of Washington, PC and EDOW Vision Center, LLC** to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above.

<input type="checkbox"/> HIV/AIDS Related Information	<input type="checkbox"/> Drug and Alcohol Information	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> Mental Health & Psychotherapy Information	<input type="checkbox"/> Sexually Transmitted Disease Information	<input type="checkbox"/> Tuberculosis

6. The Recipient of the Medical Record Information: (AN INVOICE / BILL WILL BE SENT FOR EACH RECEIPT REQUEST)

Myself (the patient or guardian) Other

Name: _____	Name: _____
Address: _____	Address: _____
E-mail:** _____	E-mail:** _____
FAX: _____	FAX: _____

**** ONLY PROVIDE AN E-MAIL ADDRESS IF YOU WANT THE MEDICAL RECORD SENT VIA THE INTERNET.**

7. Responsible Entity to be Billed for Medical Record Information:

Myself (the patient or guardian) Other

Name: * _____	Name: * _____
Address: * _____	Address: * _____
Phone: * _____	Phone: * _____

THIS IS A PATIENT REQUEST: THE PATIENT WILL BE CHARGED FOR THE MEDICAL RECORD UNLESS OTHERWISE NOTED. FEE: \$ 1.00 PER PAGE plus a Fulfillment Fee (Actual Postage).
Send these records via: _____ Internet (link to secure website) _____ FAX _____ Mail.

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I am not required to sign this authorization and that this consent may be revoked in writing at any time. With the exception to the extent that disclosure of PHI has already occurred prior to the receipt of revocation by the named provider, I may initiate revocation of this authorization. A direct written correspondence must be sent to the health care provider above within 30 days from the request.

I certify that I have read, signed and received a copy of this authorization upon my request

Signature **Date** **Relationship to Patient**

