# 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 16th 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)**

| | | |
|---|---|---|
| ☐ Entire Medical Record | ☐ Operative Reports | ☐ Pathology Reports |
| ☐ Office Notes | ☐ Cataract Surgery | ☐ |
| ☐ Consultation Notes or Letters | ☐ LASIK | ☐ 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.

| | | |
|---|---|---|
| ☐ HIV/AID Related Information | ☐ Drug and Alcohol Information | ☐ Genetic Information |
| ☐ Mental Health & Psychotherapy Information | ☐ Sexually Transmitted Disease Information | ☐ Tuberculosis |

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

PHI-nd IT™

Copy-Patient