Advanced Vision

Family Eye Care

Dr. Spencer Young
1633 Birchwood Ave. Ste. 105 Bellingham, WA 98225

Records Release

AUTHORIZATION TO SEND OR RECEIVE MY HEALTH CARE INFORMATION

Patient Name: _____

Date of Birth: _____

Authorization

- You may send the following health care information to

  _____

  Address _____

  City _____ **State** _____ **Zip** _____

I authorized **Dr. Spencer Young at Advanced Vision Family Eye Care** to **RECEIVE** complete information concerning my medical findings and treatment from Dr. _____

Check all that apply:

- All health care information in my medical record.
- Health care information in my medical record relating to the following treatment or condition : _____
- Health care information in my medical record for the date(s) : _____
- Other, specify date(s) : _____

This authorization ends 90 days from the date below unless otherwise specified.

- On (date) _____ * When the following event occurs: _____

Your Rights

You may revoke this authorization. If you do, it will not effect any actions already taken by Advanced Vision Family Eye Care based upon this authorization. You may not be able to revoke this authorization if its purpose was to obtain insurance. Submit a written request to us stating that you are revoking your consent.

The records may contain information regarding HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health and drug/alcohol use. You can elect to have this information withheld from your record.

Any information received by Advanced Vision Family Eye Care will be subject to our Privacy Policy. Once Advanced Vision Family Eye Care discloses health care information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Parent or legally authorized individual signature | Date

_____ _____

Printed name if signed on behalf of the patient representative | Relationship (parent, legal guardian, personal)