AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize CFEC to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

I authorize my health care information to be released to the following recipient(s):

Recipient's Name (spouse, partner, parent, etc.): _____

Address: _____

Phone Number: _____

Fax Number: _____

Information to be disclosed: I authorize the release of the following health information:

(check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, any treatment received by me and any medical devices pertaining to me.
- ☐ Only verbal communication regarding my account.
- ☐ Only the following records or types of health information:
  _____.

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of _____, 20____. (If no date is selected, this authorization is effective for three years.)
- ☐ Until the following event occurs:_____.

Redisclosure: I understand that my eye care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at CFEC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to CFEC at the address listed below. The revocation will be effective immediately upon my eye care provider's receipt of my written notice, except that the revocation will not have any effect on any prior action taken by my eye care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact CFEC for answers to my questions about the privacy of my health information at 9623 32nd ST SE Suite D121 Lake Stevens, WA 98258, or by telephone at (425) 377-9747.

_____ _____

Signature **Date**

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____

Name of Guardian/ Representative Legal Relationship

I DECLINE Authorization for Use/Disclosure of Information:

_____ _____

Signature **Date**