

EYE ASSOCIATES NORTHWEST, PC

1101 Madison St Ste 600

(206) 215-2020/ FAX (206) 215-2022

REQUEST FOR ACCESS TO MEDICAL INFORMATION

Eye Associates Northwest, PC (EANW) acts in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices provides information about our use of your health information. The Notice contains a Patient Rights section describing your rights under the law. You have the right to access, inspect and copy protected health care information used to make decisions about you. Please be advised of the following EANW Policy regarding release of medical records:

- EANW will make every reasonable attempt to give you access to information about yourself generated within this practice.
• Your EANW physician will review your request for records.
• EANW will provide the requested information within thirty (30) days or within sixty (60) days if your records are stored off site.
• You have the right to cancel or revoke this authorization at any time by submitting a written request to EANW asking for a cancellation of the original request. Include your complete name, date of birth, address, phone number and the name of the agency you authorized to receive the information.
• Reasonable costs, in accordance with RCW 70.02.010 (12) may be charged.

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

REQUESTING RECORDS FROM

NAME: \_\_\_\_\_

PHONE # \_\_\_\_\_ FAX# \_\_\_\_\_

I am requesting the following information:

\_\_\_ Most recent exam only
\_\_\_ Other \_\_\_\_\_

SEND RECORDS TO

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX \_\_\_\_\_

FOR OFFICE USE ONLY

I understand that my consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. EANW is specifically authorized to release all health care information relating to such testing or treatment.

Signature / Relationship to Patient

DATE \_\_\_\_\_

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE SIGNED