

Northwest Vision Clinic Records Release

2201 NW Market Street | Seattle, WA 98107 | p.206.789.7417 | f.206.789.7651

I, _____ authorize Northwest Vision Clinic, Dr. Mark D. Balter to photocopy & disclose my medical records to:

Dr/Office: _____

Address: _____

City, State, Zipcode: _____

Phone: _____ Fax: _____

I have been informed that this office will not release any information about me to any person or agency without my consent. I have read the above and also have been advised of my right to receive a true copy of this authorization. Further, I understand the contents of this written authorization in its entirety.

I understand that my express consent is required to release any health care information relating to testing for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for any of the previously mentioned conditions, you are specifically authorized to release all health care information related to such diagnosis, testing or treatment.

Signature of patient or authorized representative Date

Patient's Name: _____

Address: _____

City, State, Zipcode: _____

Phone: _____ Fax: _____

Date of Birth: _____ SS#: _____

This authorization expires 90 days after date it is signed.