THE COLUMBIA RIVER EYE CENTER
475 BRADLEY BLVD * RICHLAND WA 99352
PH 509 943 2240 * FAX 509 943 1575

AUTHORIZATION TO RELEASE/RECEIVE HEALTHCARE INFORMATION

PATIENT NAME: ____

DATE OF BIRTH: ____

I authorize THE COLUMBIA RIVER EYE CENTER to release information to/receive information from:

NAME OF PERSON, PROVIDER, OR FACILITY: -

____

ADDRESS: ____

PHONE #: ___________________________ FAX #: ___________________________________

INFORMATION TO BE RELEASED (CHECK ONE)

- The most recent 2 years (chart notes, labs, special tests).
- All medical records.
- Specific Information: ____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my consent for this information to be released.

____ ___________________________

PATIENT/PARENT/GUARDIAN SIGNATURE DATE