Bellevue Eye Specialists
10047 Main Street Suite#101
Bellevue, WA 98004
Phone (425) 698-1891 Fax (425) 559-2101

Permission to Release Patient Records

Patient's Name: _____
Date of Birth: _____
Today's Date: _____

I grant permission to Bellevue Eye Specialists to release my protected health information to:

_____

_____

_____

The medical findings and treatment disclosed should cover the period from_____ to _____. In initialing this request, I hereby release Bellevue Eye Specialists from any laws governing the disclosure of confidential or privileged information.

I understand as promptly as required under the circumstances, but no later than fifteen working days after receiving this request, my information will be released, or a notification declining release will be sent. Bellevue Eye Specialists strictly enforces Washington state law on release of protected health information. Chapter 70.02 RCW Medical Records – Health Care Information Access and Disclosure.

_____
Patient or Legal Power of Attorney's Signature

_____
If Patient is a Minor, Parent or Legal Guardian's Signature

_____
Today's Date