ballard OPTICAL

Authorization for Release of Information

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I authorize:

Ballard Optical
1719 NW Market St, Seattle, WA 98107
Ph: 206-784-2090 Fax:206-784-8939

OR

Name:_____
Address:_____
Phone:_____
Fax:_____

To use or disclose the following health information: (check one)

☐ - All of my health information (Fees for copying may apply)

☐ - My Most recent examinations (Continuing Care)

☐ - My health information covering the period from _____ (date) to _____ (date)

The above party may disclose this health information to the following recipient:

Name:_____

Address: _____

City,State, Zip. _____

Phone:_____

Fax:_____

Ballard Optical
OR 1719 NW Market St, Seattle, WA 98107
Ph: 206-784-2090 Fax:206-784-8939

The purpose of this authorization is: (check all that apply)

☐ - Personal Use ☐ - Transfer of Care

This authorization ends: (check one)

☐ - On (date)_____

☐ - When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____ Date: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient (Age 16+) or Authorized Representative (Age 0-15):

X_____ Date: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient (Age 16+) or Authorized Representative (Age 0-15):

X_____ Date: _____