Pt instructions: *If you would like your records from another physician's office to be sent to* ***TACOMA EYE*** *prior to your appointment, please complete this form and hand carry or fax to your previous doctor:*

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION to Tacoma Eye.

I, print patient name:…

_____

Patient date of birth:

_____

Legal representative name: (only complete if requester is NOT the patient):

_____

…hereby authorize (name of practice that patient is requesting records **from** with address, phone number and fax number):

_____
_____
_____
_____
_____
_____

to disclose records made in the course of my diagnosis and treatment, and prognosis with respect to any optometric or medical condition and/or treatment of myself or my minor children to give **TACOMA EYE** any and all such information. This authorization shall remain valid until **TACOMA EYE** has completed my treatment or I request termination in writing. A copy of this authorization shall be as valid as the original.

You may fax these records to **253-236-7781 ATTN: TACOMA EYE**

Signature of patient or legal representative:

_____

Date

_____

NOTE:
Releasing office is asked to complete the request within 1 calendar week of receipt. Pursuant to WA Chapter 70.02 RCW patient may be charged a fee for supplying medical records from the releasing office.