RooseveltVision

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Roosevelt Vision Source
9706 4th Ave SW, Suite 100, Seattle, WA 98115
Phone: 206-527-2987 Fax: 206-527-1208
Shawna Williams, Privacy Official

Patient Name _____ DOB_____

Patient Address _____

Patient Phone Number _____

I authorize Roosevelt Vision Source to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

To immediate family members as listed below:

_____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting, in writing or fax, to the Privacy Official noted above and in the *Notice of Privacy Practices*.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

6/24/2019