Edmonds Eyecare Associates

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize
☐ patient ☐ legal guardian for the patient

PERSONS/ORGANIZATIONS RELEASING INFORMATION

_____
_____
_____

to release the following information from the medical records of:

_____ Birth date:_____

PERSONS/ORGANIZATIONS TO RECEIVE INFORMATION

_____
_____
_____

INFORMATION TO BE DISCLOSED

_____ Last Eye Exam (including glasses/contact lens prescriptions)

_____ Records for the last 2 years. _____ All Records ($18.00 fee may apply)

Reason for Request: _____Transfer of Care _____Legal _____Other

*****Please allow at least 7 business days to process records requests*****

REDISCLOSURE PROHIBITED: This information will be disclosed from records whose confidentiality is protected by state or federal law. These laws prohibit further disclosure and/ or making copies of this information without the specific written consent of the person to whom it pertains, or otherwise permitted by state law.

I release _____, their staff and counsel from all legal responsibility that may arise from authorized release of information. I understand I may revoke this consent at any time. This consent expires on: _____ or in ninety (90) days.

_____ _____
Signature of person authorized to give consent Date of Consent

Andrew P. Davis, M.D.
General Ophthalmology
Cataract Surgery
Cornea Surgery

Bryan S. Karrick, O.D., F.A.A.O.
Primary Eye Care
Medical Eye Care
Contact Lens

Ben M. Stoebner, O.D., F.A.A.O.
Primary Eye Care
Medical Eye Care
Urgent Care Vision

Glen R. Owen, O.D., F.A.A.O.
Primary Eye Care
Medical Eye Care
Glaucoma

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