Vision Source®

WALLA WALLA

AUTHORIZATION TO OBTAIN INFORMATION

I, ________________________________, hereby authorize ____
Print Patient Name   Name of Individual/Facility/Agency

To release the following information:

☐ Contact Lens Records
☐ Eye Health Evaluations
☐ Visual Fields
☐ Health care information received from other health care providers/facilities
☐ Optic Nerve Imaging
☐ Physician Comments
☐ Refraction Findings and Lens Prescriptions

From (circle one): All Dates/Visits Last Two Exams Other: ________________________________

To:

Vision Source Walla Walla
614 East Alder, Suite #1
Walla Walla, WA 99362
Phone: 509-527-3937
Fax: 509-529-4750

For the purpose of ongoing treatment and/or continuity of care:
I hereby consent to the release of the above information. I understand that such information cannot be released without my specific consent, except in a medical emergency. I understand that information used or disclosed may be subject to redisclosure by the recipient and no longer considered protected under HIPPAA (federal law). This authorization is **valid for 90 days** unless revoked in writing earlier. I realize that I have the right to revoke my authorization at any time and that it must be in writing to be valid, except as documented in the Washington State Healthcare Information Act (section 203) and unless disclosure is required to obtain payment for care that has already been ordered. This revocation will become a permanent part of my record.

Signature: ____ Date: _______________________
Patient/Guardian/Legal Representative

Witness: ____ Relationship to the patient: ________________________
Guardian/Legal Representative-- Print

By law, Drs. Harry, Daniel, and Eric Wiessner are required to keep confidential all records of the identity, diagnosis, prognosis or treatment of patients utilizing our services.

Patient Name: __________________________________ Telephone #: (_____)_______-_____________
Print

DOB: ______ /_______ /_________ Social Security #: xxx-xx-_____________