WALLA WALLA

AUTHORIZATION TO RELEASE INFORMATION

I, ______________________________, hereby authorize Vision Source Walla Walla
Print Patient Name

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

To release the following information:

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

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

To: ___________________________ At: _____________________________________
Name of Doctor or Facility

____
Address (City, State, Zip Code)

For the purpose of (circle one)**:** **Continuity of Care** **Other:** ____

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-_____________