MOSCOW FAMILY EYE CARE

PULLMAN FAMILY EYE CARE

AUTHORIZATION TO USE DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

1) I authorize _____ and its employees, agents or associated healthcare practitioners ("PROVIDER") to use or disclose the Patient's protected health information as described below.

2) **Relevant Time Period**. PROVIDER may use or disclose information relating to healthcare provided during the following time period:
   - ☐ Anytime
   - ☐ Healthcare provided between (date) _____ and (date) _____

3) **Types of Information**. PROVIDER may use or disclose the following type(s) of information:
   - ☐ All information concerning the Patient's healthcare or payment during the relevant time period. Medical records concerning the Patient's healthcare during the relevant time period, including: Records from the Patient's chart (e.g., history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, etc.)
   - ☐ Diagnostic images, films or other recordings (e.g., x-rays, MRI scans, CT scans, etc.)
   - ☐ Billing and payment records for healthcare rendered during the relevant time period.
   - ☐ Other: _____

4) **Persons to Whom Disclosure Allowed**. PROVIDER may disclose the information to the following entity(ies):

Moscow Family Eye Care
1205 E 6th
Moscow, ID 83843
P: (208)-882-3434 F: 208-883-4229

Pullman Family Eye Care
560 SE Bishop BLVD
Pullman, WA 99163
P: (509)-334-3300 F: (509)334-7591

Colfax Opthalmology
1170 W Fairview St
Colfax, WA 99111
P: (509)-334-3300 F: (509)334-7591

5) **Purpose**. PROVIDER may use or disclose the information for the following purpose(s):

I understand that I have the right to revoke this authorization at any time except to the extent that PROVIDER has acted in reliance on this authorization. To revoke this authorization, I must submit a written revocation to the PROVIDER. I understand that PROVIDER may not condition the Patient's healthcare on this authorization unless (1) the purpose for PROVIDER's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research. I understand that information disclosed by PROVIDER pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations. This authorization will expire on the following date or event: _____. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

_____ _____

Patient Signature Date

_____

Authority or relationship to the Patient