Records Request/Release

Thurston County's Eyecare Specialists

- ☐ GARY N. SCHOLES, M.D.
  Glaucoma
  Cataract Surgery
  General Eyecare
- ☐ JAY C. RUDD, M.D.
  Cornea / External Disease
  Refractive Surgery
  Cataract Surgery
- ☐ STEPHEN D. RECK, M.D.
  Glaucoma
  Cataract Surgery
  Comprehensive Ophthalmology
- ☐ PENNY V. RECK, M.D.
  Vitreoretinal Surgery
  Diseases of the retina & vitreous
- ☐ JANE S. MYUNG, M.D.
  Vitreoretinal Surgery
  Diseases of the retina & vitreous
- ☐ GRANT D. AAKER, M.D.
  Cataract Surgery
  Comprehensive Ophthalmology
- ☐ DAVID V. PRATT, M.D.
  Facial / Eyelid Plastic Surgery
- ☐ BLAKE PERRY, M.D.
  Facial / Eyelid Plastic Surgery
- ☐ CHAD M. WAGGONER, O.D.
  General Eyecare
  Contact Lenses
- ☐ HEATHER L. MUEHLER, O.D.
  General Eyecare
  Contact Lenses
- ☐ BRIAN P. FINLEY, O.D.
  General Eyecare
  Contact Lenses

Clarus Eye Centre
345 College Street SE
Lacey, WA 98503-1014

WWW.CLARUSEYE.COM

Patient Name:____ DOB: ______________________

Guardian or Authorized Party Name *(if applicable)*: ____

Phone:__________________________________

Email:__________________________________

I authorize the use and disclosure of my health information as described below:

Information Requested:

- ❑ Records relating to treatment dates from: _______________ to: _______________
- ❑ Records for all **EYE CARE** at this facility or by this doctor.
- ❑ Other (Please specify) ______________________________

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express consent will automatically expire in 90 days from this date.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be Released: [ ] from [ ] to ____

____

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[ ] from [ ] to Clarus Eye Centre
345 College Street SE, Suite C
Lacey, WA 98503
360-456-3200
360-456-3894 fax

________(**Initials of patient or guardian**) I understand that Clarus Eye Centre may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

X____ ___________________________

Signature of Patient or Guardian** **Date**

A fax copy or photocopy of this consent shall be valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions, **I DO**_____ **DO NOT**_____ authorize the release of this information.

** If this authorization is signed by an individual's personal representative, the representative's authority is based on: ____ (e.g., state law, court order, etc.)

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. No fee shall be charged for reproducing and forwarding records directly to other physicians.

Submission: Please email completed form to medicalrecords@claruseye.com (or return via mail, fax or physical drop-off) and allow up to 10 business days for request fulfillment. We will contact you with any questions.

For Office Use Only: Date sent: ___________________ By:________________________________