CLARUS
EYE CENTRE

Thurston County's Eyecare Specialists

☐ GRANT AAKER, M.D.
Cataract Surgery
Comprehensive Ophthalmology

☐ JANE S. MYUNG, M.D.
Vitreo-Retinal Surgery & Disease
Diabetic Retinopathy
Macular Degeneration

☐ BLAKE PERRY, M.D.
Facial / Eyelid Plastic Surgery

☐ PENNY RECK, M.D.
Vitreo-Retinal Surgery & Disease
Diabetic Retinopathy
Macular Degeneration

☐ STEPHEN RECK, M.D.
Cataract Surgery
Glaucoma Consultation/Surgery

☐ JAY C. RUDD, M.D.
Cataract Surgery
Refractive Surgery
Cornea/External Disease

☐ TAMMY BURRELL, O.D.
Routine Vision Care

☐ KRISTEN CLARK, O.D.
Routine Vision Care

☐ HANNAH SONG, O.D.
Routine Vision Care

CLARUS EYE CENTRE
345 COLLEGE STREET SE, STE C
LACEY, WA 98503-1014

MAIN: 360-456-3200

FAX: 360-456-3894

WWW.CLARUSEYE.COM

RECORDS RELEASE FORM

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 _____

_____

_____

[ ] from [ ] to Clarus Eye Centre
345 College Street SE, Suite C
Lacey, WA 98503
360-456-3200 (main)
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:_____