CLARUS EYE CENTRE
Medical Records Department
345 College Street SE
Lacey, WA 98503
PH: 360-456-3200
Fax: 360-456-3894
Web: claruseye.com

Medical Records Release Form

(all Clarus Eye Centre locations)

Patient Name: _____ DOB: _____

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

Phone: _____ Email: _____

INFORMATION REQUESTED ----------

Date or Time Frame Information is Needed By: _____

[CURRENT PROVIDERS] Records for ALL eye care at this facility by:

- ☐ GRANT AAKER, M.D. (Cataracts, Comprehensive)
- ☐ ANTHONY GRILLO, M.D. (Cataracts, Refractive, Cornea)
- ☐ STEPHEN RECK, M.D. (Cataracts, Glaucoma)
- ☐ JASON LEWIS, D.O. (Oculoplastics)
- ☐ BLAKE PERRY, M.D. (Oculoplastics)
- ☐ JANE S. MYUNG, M.D. (Retina)
- ☐ PENNY RECK, M.D. (Retina)
- ☐ KRISTEN CLARK, O.D. (Optometry)
- ☐ EMILY KOZICZKOWSKI, O.D. (Optometry)
- ☐ YVETTE LAKKIS, O.D. (Optometry)
- ☐ KAREN WATSON, O.D. (Optometry)

Past Provider *or* Other (please specify): _____

Information to be released: _____TO _____FROM

Name: _____

Address

Street Address _____

Street Address Line 2 _____

City/State _____

Zip Code _____

Phone: _____ Email: _____

Additional Information or Fax # for Delivery: _____

For Office Use Only
Date Sent: _____ **By:** _____

Information to be released: _____TO _____FROM

Clarus Eye Centre (Main Location)
345 College Street SE, Suite C
Lacey, WA 98503-1014
PH : 360-456-3200
FAX : 360-456-3894

Confirmation of Medical Records Release:

- 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 made based on 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.
- 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.

Signature: _____Date: _____

Notes: _____

******An electronically submitted, faxed, 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** _____**I DO NOT** authorize the release of this information.
- If an individual's representative signs this authorization, 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:
Complete and return physical forms via mail, fax, or physical drop-off to:

Clarus Eye Centre
345 College Street SE, Suite C
Lacey, WA 98503
PH: 360-456-3200
FAX: 360-456-3894

You may also send a copy to our secure email address: ***medicalrecords@claruseye.com.***

******For all submissions, please allow up to 10 business days for request fulfillment. We will contact you with any questions.******

For Office Use Only
Date Sent: _____**By:**_____