AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I am requesting that my medical (eye) records, including prescription for eyewear to be sent to:
FAX (425) 974-7440 or **EMAIL:** bella-vision@msn.com

Patient Name:_____ **Date of Birth:** _____

Originating Doctor/Clinic: _____

Originating Doctor/Clinic Phone Number: _____

Originating Doctor/Clinic Fax Number: _____

[ ] BELLEVUE	P:425-747-7887	958 111th Ave NE Ste 102, Bellevue WA 98004
[ ] BOTHELL	P:425-486-8074	22616 Bothell Everett Hwy Ste 2, Bothell WA 98004
[ ] KIRKLAND	P:425-968-8279	328 Central Way, Kirkland WA 98033
[ ] REDMOND	P:425-881-6655	8862 161st Ave NE Ste 105, Redmond WA 98052
[ ] WOODINVILLE	P:425-485-2070	13804 NE 175th ST Ste 102, Woodinville WA 98072

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department of Bella Vision. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed, for a reasonable fee, as provided in the Code of Federal Regulations 164.524 and pursuant to Bella Vision policy.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information my not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Bella Vision's Operation Officer, in writing, at support@bellavisionusa.com.

Signature of Patient or Legal Guardian: _____**Date:** _____