Summit Eye Consultants

Jacqueline Wong, MD
945 Hildebrand Lane, Suite 235
Bainbridge, WA 98110
Phone: (206) 201-3669
Fax: (206) 451-4890

Authorization to Release Medical Information

I authorize and request the named health care provider to release the information or records specified upon request in person, by mail or fax to the address specified at the time of the request.

Patient Name: _____ DOB: _____

SS#: _____

Provider: _____ Release to: Summit Eye Consultants

Address: _____ 945 Hildebrand Lane, Suite 235

_____ Bainbridge Island, WA 98110

Phone: _____ Phone: 206-201-3669

Fax: _____ Fax: 206-451-4890

Records authorized to be released:

___ Admission history and physical ___ Office Notes

___ Medication List ___ Lab Reports

___ All Medical Information

This information will be used for:

___ Transfer of care ___Continuation of Care ___ Legal Representation

This authorization will expire one year from the date of the signature below. I understand I can revoke this authorization at the time by writing to the health care provider.

_____

Patient Signature Date

_____

Representative to patient Date