SPECTRUM EYE CARE, INC, PS

NATHAN L SCOTT, OD

126 EAST JOHNSON STREET
PO BOX 3100
CHELAN, WA 98816-3100
PHONE 509.682.2708 FAX 509.682.2713

CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City, State ZIP: _____

The information is to be released to:

Name:	Spectrum Eye Care, Inc, PS and Nathan L Scott, OD
Address:	PO Box 3100, Chelan, WA 98816-3100
Phone:	509.682.2708
Fax:	509.682.2713

I hereby give my permission for the release of information related to my medical conditions, including without limitation information regarding (check all that apply):

- ❑ All medical records
- ❑ Medical records for the following dates: _____
- ❑ Other: _____

Information regarding the following may be released (check all that apply):

- ❑ Mental health / psychiatric disorders
- ❑ Chemical dependence / substance abuse
- ❑ HIV (AIDS Virus) / Sexually Transmitted Diseases

The intent for release of this information is for (check all that apply):

- ❑ Personal
- ❑ Physician
- ❑ Attorney
- ❑ Insurance
- ❑ Other: _____

You may revoke this authorization in writing. If you do, it will not affect any actions already taken by Spectrum Eye Care based on this authorization. You may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, you must write a letter to Spectrum Eye Care. This information is subject to re-disclosure and may no longer be protected by federal or state privacy laws. This release is valid for no more than 90 days from date of signature unless I have indicated a date sooner than that here: _____.

Date: _____

Signature: _____

Print Name: _____

Relationship: _____