Corliss

OPTOMETRISTS

Kenneth J. Corliss, OD

MEDICAL RECORDS REQUEST

Date _____

Name of Patient _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Phone _____

Authorizes:

Name of Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Information to be Released:

- ❑ All clinic records
- ❑ Eye records
- ❑ Visual Fields
- ❑ Office notes
- ❑ Lab reports
- ❑ Photographs
- ❑ Allergy records
- ❑ X-Ray reports
- ❑ Immunization records
- ❑ Electrocardiograms
- ❑ X-Ray films (specify) _____
- ❑ Other (specify) _____

List other facilities records to be including when releasing for continuing medical care:

_____

For the following Dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

- ❑ Mental health
- ❑ AIDS test results
- ❑ Drug abuse
- ❑ Alcoholism
- ❑ Developmental disabilities
- ❑ AIDS-related disease diagnosis
- ❑ Other

Purpose or need for disclosure: (check applicable categories)

- ❑ Further medical care
- ❑ Payment of insurance claim
- ❑ Legal Investigation
- ❑ Application for insurance
- ❑ Vocational rehabilitation evaluation
- ❑ Personal
- ❑ Disability determination
- ❑ Other

I understand that this authorization shall be valid for one (1) year unless otherwise stated at right or revoked through written notice to Medical Records. _____ (alternate date if not one year)

I authorize release of my medical records in accordance with the specification listed above. I understand written notice is necessary to cancel this request.

Signature of patient _____ Date _____

If signed by person other than patient, state relationship and authorization to do so.

Authorized signature _____ relationship _____

Patient is: ❑ Minor ❑ Incompetent ❑ Disabled ❑ Deceased

Legal Authority: ❑ Legal ❑ Legal guardian ❑ Next of kin of deceased

312 4th Street. SE • Puyallup, WA 98372 • 253-845-0585 • Fax 253-845-1939 •

CO
Corliss
OPTOMETRISTS
Kenneth J. Corliss, OD

DISCLOSURE OF INFORMATION TO THIRD PARTY

Date: _____

Patient: _____

Your signature below authorizes our office to discuss your office information with regards to insurance and personal liability, diagnosis, medical history and treatment with persons listed herewith.

Name/Relationship _____ Phone # _____

Name/Relationship _____ Phone # _____

Name/Relationship _____ Phone # _____

Patient's Signature _____

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corliss_staff@doctorcorliss.com

CO

Corliss

OPTOMETRISTS

Kenneth J. Corliss, OD

RECORDS RELEASE

Date of Request: _____

Please release my records to the following doctor or clinic:

_____

_____

_____

_____

Patient's Name: _____

Date of Birth: _____

Patient's Signature _____

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