Rolling Hills Eyecare
1045 N Grand Avenue, Ste E
Pullman, WA 99163
PH: (509) 334-3610
Fax: (509) 334-1436

Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

Name: _____ **Date:**
Date of Birth: _____
Email: _____

Please allow a minimum of seven business days to process the request.

I, _____ , authorize:

(Person or Facility) _____ to

Address:	
Phone:	**Fax:**

☐ **Disclose to**
☐ **Obtain from**

Rolling Hills Eyecare Pullman via fax, email (secured server), paper (I understand that all records will be mailed) or direct email

Access and/or disclosure of the following records for the dates of service: ____/____/____ to ____/____/____.

Check appropriate boxes below:

☐ Chart notes including spectacle and contact lens Rx
☐ Billing Records
☐ Diagnostic Images (retinal photos, visual fields)
☐ Other _____

I have read and understand the following statements:

1. I understand that Rolling Hills Eyecare Pullman may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused, Rolling Hills Eyecare Pullman will not release the information as requested in this Authorization, and I will be notified of the denial/refusal in writing.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
3. I understand that Rolling Hills Eyecare Pullman will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.
4. I understand that I may revoke this Authorization at any time by notifying Rolling Hills Eyecare Pullman in writing, but if I do, it will not have any effect on any actions Rolling Hills Eyecare Pullman took before it received the revocation.
5. I understand that there is potential for information disclosed based on this authorization to be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rule.
6. I understand that I may see and copy the information described on this form if I ask for it, and that I shall receive a copy of this form after I sign it if the request for disclosure was initiated by Rolling Hills Eyecare Pullman .
7. I understand this Authorization will expire on _____/_____/_____ or when the following event occurs: _____.
   If no expiration date, event or condition is noted this authorization will expire 1 year from the date signed. This authorization is valid for information created within 12 months after the date this authorization is signed, as well as past information. I understand it is my responsibility to notify Rolling Hills Eyecare Pullman to initiate follow-up requests based upon this standing authorization.

Patient Signature or Authorized Person	Patient's Name or Authorized Person	Date

Ref: 45 CFR 164.524(c)(2)(i) https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

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