Overlake EyeCare, P.S.
We're Focused On You

MEDICAL RECORDS / RELEASE OF INFORMATION (ROI) AUTHORIZATION FORM

Overlake Eyecare PS | 1837 156th Ave NE, Suite 201, Bellevue, WA 98007 | P: 425-643-2020 | F: 425-643-0859

If you circle A: please print to complete. Please fax this form to 425-643-0859 or bring it in person to our office

Last Name: _____ **☆EYE CLINIC OF BELLEVUE CLOSED SINCE JUL 2026☆**

First Name: _____ **Email:** _____

I. MY AUTHORIZATION: PLEASE CIRCLE "A" or "B":

"A"	"B"
I would like my medical records sent to myself or another facility and will not establish continuing care with Overlake Eyecare PS. I am using Overlake Eyecare PS as a medical records custodian function. *Please checkmark which method of record retrieval you desire for payment processing*: ☐ $6.50= ELECTRONIC medical records charge via fax, password-protected email, OR thumbdrive for pickup ☐ $25.00= clerical fee of PAPER records for pickup (up to 25 pages) ☐ $25.00+ = $25 clerical fee of PAPER records + $0.88/page for all additional pages + shipping label to mail out to provided address	**I am a current or future patient at Overlake Eyecare PS and would like continuing care.** **Overlake Eyecare PS is acting on my behalf and would like to:** ☐ **disclose** ☐ **request** **the following health care information of…** **PATIENT LAST NAME:** _____ **PATIENT FIRST NAME:** _____ **PATIENT DATE OF BIRTH:** _____

☑ C. Overlake Eyecare may disclose or request the following information (checkmark all that apply):

☐ Last 3 chart visits
☐ All health care information in my medical record
☐ Other (e.g., scans, operative reports, misc) - specify date(s): _____

☐ **You may disclose this health information to:**
☐ **You may request this health information from:**

Name of designated recipient/ PCP/ organization: _____
Address: _____
City / State / Zip: _____ State: _____ Zip: _____
Phone Number: _____
Fax Number: _____
Email: _____
Reason(s) for disclosure: _____

☑ D. I want to receive these medical records via (checkmark one; costs may apply as in "A"):

☐ Fax ☐ Password-Protected E-Mail ☐ Pickup of Thumbdrive (Bellevue) ☐ Pickup of Paper Packet (Bellevue) ☐ Shipping Address

II. MY RIGHTS

This authorization is valid until provided written or electronic notice of revocation is provided. I authorize the releasing individual or group listed above to release or obtain health information identifying me to the receiving individual or group including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services under the following terms and conditions. I understand I cannot revoke this authorization retroactively for information already released.

Authorized Signatory: **Date:** **Time:**

_____ _____ _____