Karl B. Czirr, O.D.
CanyonView Family Eye Care
4309 W 27th Place, Suite B102
Kennewick, WA 99338
(509) 737-2010
FAX: (509) 591-0012

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION TO DR CZIRR

Patient Name _____ D.O.B. _____

I hereby authorize the doctor/doctor's office listed below to release my records to Dr. Karl B. Czirr, O.D. in regards to my eye health and vision history for the purpose of continuing ongoing care. Please include the following information:

□ All vision, medical and personal information regarding the care of my eye health

□ Only records regarding my vision, prescription and/or contact lens information

□ Other _____

Doctor/Office _____

Doctor Phone#: _____ FAX #:_____

TO THE PATIENT

It is completely your decision whether or not to sign this authorization form. If you choose to revoke this authorization, you simply need to send a written request to the office listed above to initiate the process. You cannot revoke this authorization for actions taken in reliance upon the authorization. But you may revoke authorization for further actions. When your health information is disclosed, as provided in this authorization, the recipient has a duty to protect its confidentiality. The manner in which the recipient then maintains the information is the sole responsibility of the recipient. Dr. Czirr will make every effort to ensure that any information received by our office is maintained safely by our office.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____
Date Patient/Guardian Signature

If you are signing as a personal representative of the patient, and are not their parent or guardian with legal authorization to sign on their behalf, describe your relationship to the patient and the source of your authority to sign this form

_____ _____
Relationship to Patient Print Name

_____
Source of Authority (if not parent or guardian)