



Laura Fischer, OD
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: Lakeside Vision, PLLC
Address: 22106 E. Country Vista Dr. Suite A
City: Liberty Lake State: WA Zip Code: 99019

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
- All healthcare information
- Other

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.