

Lake Oswego Eye Clinic 530 First St, Suite A Lake Oswego, OR 97034 Office: (503) 636-9608

Fax: (503) 636-9600

Integrated Eye Center 160 NW 2nd Ave Canby, OR 97013 Office: (503) 263-3937

Fax: (503) 263-3938

To request release of your Medical Records:

- 1. Complete the attached authorization form.
- 2. Once the authorization has been verified, the Release of Information Department will fulfill your request within ten business days. Requests for images on CD or records being retrieved on paper chart may take longer (up to 30 days). If you are requesting records from Dr. Tabor your chart is on paper and will require a records search; retrieval and copying fees will apply.
- 3. If fees apply, our office will send you an invoice. Once payment has been received, records will be sent by the chosen delivery method. Please note that all imaging requests (OCT) must be mailed via USPS Priority Mail as colored imaging cannot be faxed. When mailing via USPS Priority mail we will provide you with tracking information so you can ensure your records have been delivered.

If records are being transferred directly to another physician's office, chart notes from the last two calendar years, along with the most recent HVF testing performed in that period, will be faxed free of charge. We will release records free of charge one time. All OCT requests will incur an image copying charge.

FEE SCHEDULE

There may be fees for the release of records as permitted by state law (ORS 192.563).

Pages 1-10: Complimentary*

Pages 11-50: Processing fee of \$30 + \$.50 per page*

Pages 51+: \$.25 per page*

For copies of images on CD: \$20

Express Processing \$30.00



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Office: (503) 263-3937 Fax: (503) 263-3938 Lake Oswego Eye Clinic

530 First ST, Suite A Lake Oswego, OR 97068 Office: (503) 636-9608 Fax: (503) 636-9600 Authorization to Release Medical Information

Relation to Patient:

Patient Name		Phone #:	C	OOB:/	/
Patient Address:					
I authorize: Patrick J Greg	g MD PC, Gareth Tab	or MD, Phd, Lake	e Oswego Eye Cli	nic, Integrat	ed Eye Center
to release the following info	rmation to : Name and	d Address OR Fa	x# of Physician o	r Facility	
Last 2 Calendar Year	s- No charge	Comp	olete Medical Reco	ord	
Specific Information C	NLY. Please include:				
OCT		Specta	cle/Contact Lens I	Measuremen	ts
Visual	Field	Other (please specify):		
If the information to be discleded relating to the use and discleded disclosed if I place my initia	osure of the information	on may apply. I ur	derstand and agre		
HIV/AIDS inf	ormation	Mental I	nealth information		
Genetic testi	ng information	Alcohol/	/Drug diagnosis, tr	eatment, or r	eferral info
PATIENT INFORMATION not affect my ability to o where refusal to sign me of the purpose of provid make that disclosure.	btain health care serv eans I will not receive	ices or reimburse health care servic	ment for services es is if the health	. The only cir care service:	cumstance s are solely
I understand I may revok taken in reliance upon th		n writing at any tin	ne, except to the e	extent that ac	tion has been
I understand that the in subject to redisclosure understand that federal treatment or referral int redisclosure.	and no longer be pr I restricts redisclosu	otected under fed re of alcohol and	deral law. Howeve chemical depend	er, I also dency diagn	
There may be fees for pr apply.	oviding copies or retr	eieving records fro	om storage. You w	ill be informe	ed if fees
SIGNATURE I have read th	nis authorization and I	understand it.			
Ву:	OR PERSONAL REPRESEN		Date:		
(INDIVIDUAL	OR PERSONAL REPRESEN	ITATIVE)			

Print Name:_____