Authorization to Release Medical Information

Patient Name____________________________ Phone #:____________________ DOB:____/____/____

I authorize information release from:

____

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Please send my records to:

◯ **Lake Oswego Eye Clinic**
530 First ST, Suite A
Lake Oswego, OR 97068
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

____ Complete Medical Record

____ Specific Information ONLY. Please include:

_____ Ophthalmology Chart Notes _____ Spectacle/Contact Lens Mesurements

_____ Visual Field _____Other (please specify):__________________

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information _____ Mental health information

_____ Genetic testing information _____ Alcohol/Drug diagnosis, treatment, or referral info

PATIENT INFORMATION I understand that I do not need to sign this authorization and refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely of the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure.

I understand I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

SIGNATURE I have read this authorization and I understand it.

By:____ Date:______________________________
(INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Print Name:____________________________________ Relation to Patient: ______________________

Rev Nov. 2015