OREGON EYE SPECIALISTS, P.C.
PHYSICIANS & SURGEONS
DISEASES & MICROSURGERY OF THE EYE
www.oregoneyes.net

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS CONTINUITY OF CARE

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(503) 692-3630
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Patient Name: _____ Phone #: _____ DOB: ____ / ____ / ____

I authorize _____ to release the following information to Oregon Eye Specialists, P.C.:

☐ Complete Medical Record

☐ Specific Information ONLY. Please include:

☐ Ophthalmology Chart Notes ☐ Spectacle/Contact Lens Measurements

☐ Visual Fields ☐ Records created ____ / ____ / ____ to ____ / ____ / ____ only.

☐ Other (please specify): _____

Please send my protected health information to Oregon Eye Specialists, P.C. at:

☐ 18345 SW Alexander St., Suite A Aloha, OR 97006	Fax: (503) 649-9556
☐ 4035 SW Mercantile Drive, Suite 216 Lake Oswego, OR 97035	Fax: (503) 636-3055
☐ 1130 NW 22nd, Suite 630 Portland, OR 97210	Fax: (503) 241-0587
☐ 19250 SW 65th Ave., Suite 215 Tualatin, OR 97062	Fax: (503) 692-3420
☐ 434 Villa Road Newberg, OR 97132	Fax: (503) 538-1343
☐ 5050 NE Hoyt St., Suite 445 Portland, OR 97213	Fax: (503) 231-2720
☐ 1380 E Powell Blvd. Gresham, OR 97030	Fax: (503) 492-4107
☐ 9155 SW Barnes Road, Suite 336 Portland, OR 97225	Fax: (503) 296-0635

I understand additional laws require specific consent if my medical record contains any of the information listed below and that by initialing in the box corresponding to the record type I agree to have these types of records released, if they exist.

INITIAL Mental Health Information INITIAL Genetic Testing Information

INITIAL HIV/AIDS Information INITIAL Drug/Alcohol Diagnosis, Treatment or Referral

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

Refusal to sign this authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health care services is if the health services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

I have read this authorization and understand it.

_____ _____ _____
Date Signature of Patient or Legal Representative Relationship to Patient

Unless revoked, this authorization expires in 24 months or shall remain in effect for a period of time reasonably needed to effect the purpose for which it was gained.