Oregon Eye Specialists, PC

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS CONTINUITY OF CARE

PHYSICIANS

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ALOHA
18345 SW Alexander St, Suite A
P 503.642.2505 | F 503.649.9556

LAKE OSWEGO
9 Monroe Parkway, Suite 160
P 503.636.2551 | F 503.636.3055

NEWBERG
2318 Portland Road, Suite 300
P 503.538.1341 | F 503.538.1343

PORTLAND – PROVIDENCE
5050 NE Hoyt St, Suite 445
P 503.231.0166 | F 503.231.2720

PORTLAND – ST. VINCENT
9135 SW Barnes Rd, Suite 961
P 503.292.0848 | F 503.296.0635

TUALATIN - MERIDIAN PARK 19250
SW 65th Ave, Suite 215
P 503.692.3630 | F 503.692.3420

ADMINISTRATION
6420 SW Macadam Ave, Suite 160
Portland, OR 97239
P 503.244.8601 | F 503.244.3013

PATIENT ACCOUNTS
P 503.244.1232 | F 503.244.8738

www.oregoneyes.net

Int. 134 (Rev5/19)

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 note that USB devices will not be accepted.*

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

☐ 18345 SW Alexander St., Suite A, Aloha, OR 97003	Fax: (503) 649-9556
☐ 9 Monroe Parkway, Suite 160, Lake Oswego, OR 97035	Fax: (503) 636-3055
☐ 2318 Portland Road, Suite 300, Newberg, OR 97132	Fax: (503) 538-1343
☐ 5050 NE Hoyt St., Suite 445, Portland, OR 97213	Fax: (503) 231-2720
☐ 9135 SW Barnes Rd., Suite 961, Portland, OR 97225	Fax: (503) 296-0635
☐ 19250 SW 65th Ave., Suite 215, Tualatin, OR 97062	Fax: (503) 692-3420

Clinic Email: _____

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 ____ HIV/AIDS Information

INITIAL ____ Genetic Testing 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.

_____ _____

Signature of Patient or Legal Representative Relationship to Patient

Date _____

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.