Oregon Eye Specialists, P.C.

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

GRESHAM
1380 E Powell Blvd
P 503.491.9277 | F 503.492.4107

LAKE OSWEGO
4035 SW Mercantile Dr, Suite 216
P 503.636.2551 | F 503.636.3055

NEWBERG
434 Villa Rd
P 503.538.1341 | F 503.538.1343

PORTLAND – GOOD SAM
1130 NW 22nd Ave, Suite 630
P 503.227.1409 | F 503.241.0587

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

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727 S Wahanna Rd, Suite 101
P 503.717.7690 | F 503.717.7631

TILLAMOOK
980 Third St, Suite 100
TF 877.777.9026 | 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 218
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503.244.8601 | F 503.244.3013

Patient Accounts
503.244.1232 | F 503.244.8738

www.oregoneyes.net

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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 Dr., Suite 216, Lake Oswego, OR 97035	Fax: (503) 636-3055
☐	1130 NW 22nd Ave., 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
☐	9135 SW Barnes Rd., Suite 961, 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.

_____ _____

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.