Oregon Eye Specialists, PC

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient Name: ______________________________
Phone #: ____________________ DOB: ____________

I authorize Oregon Eye Specialists, PC (Practice) to use and disclose a copy of the health information described below to:

☐ Self ☐ Other ______________________________

Address ______________________________

City, State, Zip ______________________________

Fax (_______) ______________________________

The health information to be usedf and disclosed uncludes the information specifically authorized below as well as all information in my health records.

_____ By initialing here, I specifically consent to the disclosure of my HIV/AIDS information

_____ By initialing here, I specifically consent to the disclosure of my mental health information

_____ By initialing here, I specifically consent to the disclosure of my genetic testing information

_____ By initialing here, I specifically consent to the disclosure of my drug and alcohol diagnosis, treatment, or referral information, which under federal law requires a description of how much and what kind of information is to be disclosed

_____ I would like the health information disclosed to include records prior to the last three (3) years
Specify timeframe:____________________

I have reviewed and I understand this Authorizaation. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. Unless revoked earlier, this authorization shall remain in effect until my death.

You have the right to revoke this Authorization at any time provided that you do so in writing and accept to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent that you signed this Authorization as a condition of insurance coverage. To revoke this Authorization please contact the clinic. We cannot condition our provision of services or treatment to you on the receipt of this signed Authorization.

Date _____ / _____ / _____

______________________________ ____________________
Signature of Patient or Legal Representative Relationship to Patient

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