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**We Deliver  
Clarity**

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 used and disclosed includes 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 Authorization. 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