EyeHealth NORTHWEST

Authorization to Release Medical Information

South Clinics:
FAX (503)656 4249
Oregon City
Milwaukie
Sunnyside
Wilsonville
Lake Oswego-Fax (503)636-3055
Newberg-Fax (503)538-1343

East Clinics:
FAX (503)252-1797
Southeast Portland
Gresham
Northeast Portland(Providence)
Mt. Tabor
Providence Portland-Fax (503)231-2720

West Clinics:
FAX (503) 222-0614
Northwest Portland
Peterkort
Tigard
Hillsboro
Aloha-Fax (503)649-9556
Providence St. Vincent-Fax (503)296-0635

Medical Record #

Patient Name _____ Other Name _____

Birthdate _____

Current Address _____

Daytime Phone # _____

REASON FOR RECORD
- ❑ Personal
- ❑ Medical Care
- ❑ Benefits
- ❑ Litigation
- ❑ Workman's Comp
- ❑ Other

I AUTHORIZE INFORMATION RELEASE FROM:

Name of Facility

Name of Physician

Address

City, State, Zip

PLEASE SEND MY RECORDS TO: _____

Facility to Receive Information

Title (Physician, Healthcare Facility, etc.)

Address

City, State, Zip

Type of Information to be Released

❑ **Specific Information Only Please** PLEASE INCLUDE: ❑ Ophthalmology Chart Notes ❑ Visual Fields

❑ Other _____

❑ **General Medical Records (from the past two years only)**

Notes:

Protected or Sensitive Information

Certain information cannot be released without specific authorization. Please initial below **if you agree to release the following:**

_____ *Initials* I recognize that the information disclosed may contain DRUG/ALCOHOL information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ *Initials* I recognize that the information disclosed may contain MENTAL HEALTH information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ *Initials* I recognize that the information disclosed may contain data regarding HIV/AIDS testing. I specifically consent to disclosure of such information.

Permission to Fax Information: ☐ Yes ☐ No

_____ *Initials* I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, *except:* to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event) _____

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.

THERE MAY BE FEES FOR PROVIDING COPIES.

Signature of Patient or Patient's Legal Representative

Date _____ Time _____

Print Patient's Name or Name of Patient's Legal Representative (if applicable)

Relationship to Patient

❑ Patient's or Legal Representative's Personal Identification Verified