EyecareAssociates

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS, PER ORS192.525

Release From (Please include complete name and address	Release To (Please include complete name and address

Patient name(PLEASE PRINT) _____ **DOB** _____

By initializing the space below, I specifically authorize the release of the following medical records, if such records exist:

_____ Please send the entire medical record (this will be limited to a five year history) to the above named recipient.
***Eyecare Associates reserves the right to charge for the cost of copying the records.*

_____ Most recent two year history
_____ Laboratory reports
_____ Change of Primary Care Physician
_____ Diagnostic imaging reports
_____ Other (Specify) _____

_____

_____ HIV/AIDS related records (Must be initialed to be included in other documents)
_____ Mental health information (Must be initialed to be included in other documents)
_____ Genetic testing information (Must be initialed to be included in other documents)
_____ Drug/alcohol diagnosis, treatment or referral information: Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information below.)
_____ This authorization is limited to the following treatment:
_____ This authorization is limited to the following time period:
_____ This authorization is limited to a workers' compensation claim for injuries of _____ _____ on (date) _____.

DISCLOSURE STATEMENT

I understand that once the information is disclosed pursuant to this authorization, it may be de-disclosed by the recipient without the knowledge or consent of Eyecare Associates, pc or you. This information may not be protected by Federal privacy regulation. This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, **this consent will expire 180 days from the date of signing** or shall remain in affect for the period reasonably needed to complete the request. Your general medical information may contain references to your mental state, drug and alcohol conditions, or HIV status or sexually transmitted diseases. Full release of this information requires additional authorized initials (see above). We make every effort to prevent release of this information. However, we cannot guarantee that every reference to these conditions has been removed from your general medical record.

Signature of patient or person authorized by law (required)	**Date**

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Albany, OR 97321
(541) 926-5848
Fax: (541) 926-2873

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Lebanon, OR 97355
(541) 451-5808
Fax: (541) 451-5813

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Corvallis, OR 97330
(541) 752-4622
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