Vision Source

OPTOMETRIC PHYSICIANS

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name_____ D.O.B. _____

Current Address _____

City/State/Zip _____ Phone # _____

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

I AUTHORIZE MY INFORMATION TO BE RELEASED FROM:

Name of Physician: _____

Clinic Address: _____

_____

Phone: _____

Fax: _____

PLEASE SEND MY INFORMATION TO:

Happy Valley Vision Source

Phone: 503-252-2375 | Fax: 503-251-3761

Email: Frontdesk@happyvalleyvision.com

TYPE OF MEDICAL INFORMATION TO BE RELEASED

○ All PERTINANT CHART NOTES ○ VISUAL FIELDS ○ RETINAL IMAGES ○ SPECTACLE RX ○ C-LENS RX

○ OTHER _____

INFORMATION MAY NOT BE COMPLETE WITHOUT INITIALING BELOW:

_____ THE RECORDS DISCLOSED MAY CONTAIN DRUG/ALCOHOL INFORMATION. THIS INFORMATION IS PROTECTED BY FEDERAL LAW. BY INITIALING I CONSENT TO DISCLOSE THIS INFORMATION.

_____ THE RECORDS DISCLOSED MAY CONTAIN MENTAL HEALTH INFORMATION. BY INITIALING I CONSENT TO DISCLOSE THIS INFORMATION.

_____ THE RECORDS DISCLOSED MAY CONTAIN HIV/AIDS TESTING INFORMATION. BY INITIALING I CONSENT TO DISCLOSE THIS INFORMATION.

PERMISSION TO FAX INFORMATION: ○YES ○NO

_____ BY INITIALING I CONSENT TO DISCLOSE THIS INFORMATION VIA FAX.

MY CONSENT FOR THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME WITH WRITTEN CONSENT. THIS OPTION TO REVOKE IS ONLY VALID PRIOR TO RECORDS BEING RELEASED PER MY REQUEST. THIS AUTHORIZATION WILL EXPIRE 180 FOR DATE OF SIGNING IN THE STATE OF OREGON, OR 90 DAYS IN THE STATE OF WASHINGTON. I ACKNOWLEDGE THAT UNDER OREGON LAW THE RELEASING FACILITY HAS 30 DAYS FROM DATE OF SIGNING TO RELEASE MY MEDICAL RECORDS.

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENATIVE DATE

_____

PRINTED NAME OF SIGNOR RELATIONSHIP TO PATIENT