INFOCUS EYE CARE **2450 NE Mary Rose Place, Bend OR 97701 541-318-8388 Fax: 541-318-7145**

AUTHORIZATION TO USE & DISCLOSE MEDICAL RECORDS

This authorization must be written, dated & signed by the PATIENT or by a PERSON AUTHORIZED by law to give this authorization.

I authorize _____ to use and disclose a copy of the specific health
(Name of entity disclosing information)
information described below regarding:

_____
(Printed NAME & Date of Birth of patient)

Consisting of: (by initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist).

___ All Ophthalmology Records ___ All Hospital Record ___ Lab Reports ___ Pathology Reports
___ Diagnostic Imaging Reports ___ Please send the entire medical record / all information

To: _____
(Name & address of recipient or recipients)

For the purpose of: (describe each purpose of this disclosure or indicate that the disclosure is at the request of the individual)

_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

___ HIV/AIDS information ___ genetic testing information
___ mental health information ___ drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health, genetic testing, and drug/alcohol diagnosis, treatment or referral information.

THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME. UNLESS REVOKED EARLIER THIS CONSENT WILL EXPIRE 180 DAYS FROM THE DATE OF THE SIGNING. ***I authorize this information to be FAXED, MAILED, or picked by the recipient.***

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires 180 days from date I sign it.

BY: _____ Date:_____
Signature - Individual/Patient or Personal Representative

Description of Personal Representative's authority: _____

This request will be fulfilled no later than 30 days from date of signing. If records are needed URGENTLY, please specify below the date they are needed to be received and reason for URGENCY.

Needed by: _____ Reason: _____

Request completed by: _____ Date: _____

MAILED FAXED READY FOR PICKUP by Individual Date: _____