INFOCUS EYE CARE **2450 NE Mary Rose Place, Ste 110 Bend OR 97701**
541-318-8388 Fax: 541-318-7145

AUTHORIZATION TO USE & DISCLOSE MEDICAL RECORDS

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

I authorize _____ to ***provide (disclose)*** specific health information as described below for:

_____

(Printed NAME & Date of Birth of patient)

Consisting of: (*by marking the spaces below, I specifically authorize the release of the following medical records, if such records exist).* The **past two years** of treatment records, unless specified differently below will be sent and / or are requested. **DATE RANGE: _____ to _____**

☐ Eye Exam/Treatment Notes ☐ Eye Operative Reports ☐ Lab Reports ☐ Pathology Reports
☐ Eye Testing Reports ☐ Other _____

TO:_____

_____

_____

(name, address, phone or FAX # of recipient)

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

_____

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 COPIED and FAXED, MAILED, Secure Emailed, or picked up by the recipient. If you desire a special media such as a Flashdrive, let us know at time of request.***

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 by. There may be a fee for release of records if not sent to another medical provider

Records Needed by: _____ Reason:_____

Request completed by: _____ Date: _____

◯MAILED ◯EMAILED ◯FAXED READY FOR PICKUP by Recepient Date: _____