Authorization for Release of Medical Records – INCOMING

I authorize _____
(Name, Address, Phone, Fax # of where records are being requested from)

to release information requested for:

_____ with a DOB of _____
First and Last Name

To: **ORION EYE CENTER/DESCHUTES EYE CLINIC at 1775 SW Umatilla Ave Redmond, OR 97756**
Phone: (541) 548-7170 Fax: (541) 548-3842.

For the purpose of: _____
Reason records are being requested (continuity of care, transfer of care, personal etc.)

By INITIALING the spaces below, I specifically authorize the release of the following records, if such records exist:

___ **Most recent 1-year history**
___ Pathology/Lab reports
___ Surgical reports/chart notes
___ Diagnostic Imaging/testing reports
___ Clinician office chart notes
___ Other: _____

I authorize the information listed below to be used, disclosed or received by placing my INITIALS next to the information:
___ HIV/AIDS related records
___ Genetic testing information
___ Mental health – List specific information requested: _____
___ Alcohol and drug information

Must be initialed to be included in other documents. Records will not be released without your initials specifying that you have granted this specific release authority.

This authorization is limited to the following time period: _____
This authorization is limited to a worker's compensation claim injuries of: _____

My signature indicated that I authorize the disclosure of the above information and understand the following:

I understand I may choose to not sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.

I understand I can cancel permission to use and disclose my health information at any time in writing. 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 effect for the period reasonably needed to complete the request.

I understand this change will not affect information that has already been shared.

I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share my information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Legal/Personal representative authorized by law) (Date)