

**Authorization for Release of Medical Records – OUTGOING**

I authorize **ORION EYE CENTER/DESCHUTES EYE CLINIC at 1775 SW Umatilla Ave Redmond, OR 97756**  
**Phone: (541) 548-7170, Fax: (541) 548-3842** to release information requested for:

\_\_\_\_\_ with a DOB of \_\_\_\_\_  
First and Last Name

To: \_\_\_\_\_  
Name of provider/clinic and address of where records should be sent

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:

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Most recent 1-year history (No fee if &lt;10 pages)</b> | <input type="checkbox"/> Diagnostic Imaging/testing reports |
| <input type="checkbox"/> Pathology/Lab reports                                      | <input type="checkbox"/> Clinician office chart notes       |
| <input type="checkbox"/> Surgical reports/chart notes                               | <input type="checkbox"/> Other: _____                       |

*There is no charge for records if they are delivered in electronic format (secure email, electronic fax, CD etc.)*

**FOR PAPER PRINTED COPIES OF RECORDS ONLY** - If my complete record is more than 10 pages, I understand there is a **\$30.00** fee associated with this service.

Initials of staff: \_\_\_\_\_ Fees collected: \_\_\_\_\_

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)