

1226 NE 7th Street
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Physicians & Surgeons • Ophthalmology

MEDICAL RECORDS RELEASE

Date of Request _____

Patient Name _____ Patient DOB _____

I authorize the custodian of records to disclose/release the following information* (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Laboratory/pathology records | <input type="checkbox"/> Billing records |
| <input type="checkbox"/> X-ray/radiology records | <input type="checkbox"/> Pharmacy/prescription records | <input type="checkbox"/> Surgery records |
| <input type="checkbox"/> Other (describe specifically) _____ | | |

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information.*

Please send the records to / from: **Cascade EyeCare Center, PC**
1226 NE 7th Street
Grants Pass, OR 97526.

Records may be faxed to 541-476-6690.

Please send the records to / from: _____

Records may be faxed to _____.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient Parent/Guardian Guarantor

Signed _____ Date _____

Printed name of patient representative _____

Representative's authority to sign for patient (i.e. parent, guardian, power of attorney)