AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

La Pine Eyecare Clinic
16410 Third Street, Suite A
MAILING ADDRESS:
PO BOX 3120
La Pine, OR 97739
Phone: (541) 536-2911 Fax: (541) 536-2913
Stacey Yeager, Privacy Official

Patient Name _____

Patient Date of Birth _____

Patient Phone Number _____

I authorize the following provider or health care entity (list address and phone number if known)

_____,
to release all past health information relating to the care of the patient listed above to disclose the specified information below to La Pine Eyecare Clinic (check all that apply):

- □ All ophthalmology records, including all copies of ophthalmological testing results such as visual field testing, OCT, photos, surgical procedures, drug prescriptions, refractive prescriptions for glasses and contact lenses, etc.
- □ All health and medical records including lab test results.
- □ I do not want information disclosed about substance abuse, mental health conditions, and HIV infection or AIDS (check box if you do not want this information disclosed).
- □ Other: _____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.
I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Signature **Date**

_____
Printed Name
(If you are signing as a personal representative of the patient, please indicate your relationship)

_____ _____ _____
Representative Signature Printed Name Relationship to Patient(parent, spouse, POA)