Jason Gross, M.D.
Kent Reynolds, O.D.
2460 Willamette Street
Eugene, Oregon 97405
Phone: 541-683-3744
Fax: 541-683-6672

Eugene Eye Clinic, LLC
Authorization to Use/Disclose Health Information

This Authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization*.

Patient Name (Printed) _____ D.O.B. _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

I authorize this information to be released:

From: _____ / _____
Individual or Facility Phone Number

_____
Mailing Address, City/State, Zip

To: _____ / _____
Individual or Facility Phone Number

_____
Mailing Address, City/State, Zip

Facility Fax to Send Records: _____

The purpose of this request is:

- ☐ Personal Request
- ☐ Referred Medical Care (Specialist)
- ☐ Transferring Care
  - ☐ Relocation
  - ☐ Personal Preference
  - ☐ Other _____
- ☐ Clinical Research
- ☐ Billing Purposes
- ☐ Other _____

The purpose of this request is at the request of the individual.

Type of information to be released:

_____*All Medical Records (Last 2 years of information unless otherwise indicated)

_____Physicians Notes

_____Imaging Reports and/or Films (circle one or both)

_____Lab and/or Pathology Reports (circle one or both)

_____Hospital Records/Consultations

_____Physical Therapy Reports

_____Worker's Comp Injury Records

_____Immunization Records

_____Billing Information

_____Other _____

Must be initialed to be included in other documents

_____HIV/AIDS - related records

_____Mental health counseling and/or treatment information, including information regarding depression, anxiety, and stress.

_____Genetic testing information

_____Drug/alcohol diagnosis, treatment or referral information (Federal regulation, 42CFR Part 2, requires a description of how much and what kind of information is to be disclosed). If applicable, complete restriction box below.

Your health care and payment for health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of: 1) Creating health information about you to be disclosed to a third party; or 2) For the purpose of research. You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the attention of Privacy Officer at Oregon Medical Group, P.O Box 1648 Eugene, OR. 97440, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization and the state in which you are revoking this Authorization. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. This Authorization will expire on the earlier of _____(date), 180 days from the date of signing, or the end of the period reasonably needed to complete disclosure for the above-described purpose.

Restrictions - Initial & complete if applicable:

_____ This authorization is limited to the following time period: _____

_____ This authorization is limited to the following treatment: _____

Patient Authorization to Release Information

I specifically give authorization to fax my medical information. I understand that risk is involved in faxing records and confidentiality at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instruction for returning misdirected information. _____ (Initials)

_____ _____ _____

Signature of Patient or Legally Responsible Person* Relationship to Patient Date