



## EYES OF OREGON – LAKE OSWEGO

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### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PREVIOUS NAME (IF APPLICABLE): \_\_\_\_\_

I REQUEST AND AUTHORIZE \_\_\_\_\_ TO

RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

THIS REQUEST AND AUTHORIZATION APPLIES TO:

\_\_\_ HEALTHCARE INFORMATION RELATING TO THE FOLLOWING TREATMENT, CONDITION, OR DATES:

\_\_\_\_\_

\_\_\_ ALL HEALTHCARE INFORMATION

\_\_\_ OTHER: \_\_\_\_\_

\_\_\_ YES \_\_\_ NO I AUTHORIZE THE RELEASE OF ANY RECORDS REGARDING DRUG, ALCOHOL, OR MENTAL HEALTH TREATMENT TO THE PERSON(S) LISTED ABOVE.

\_\_\_ YES \_\_\_ NO I AUTHORIZE THE RELEASE OF RECORDS VIA EMAIL, AND HAVE BEEN INFORMED OF THE POTENTIAL RISKS

PATIENT OR GUARDIAN SIGNATURE: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_ (THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED)

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