OREGON TRAIL | EYE CENTER, PC

Authorization to Release Information to Family, Friends, or Legal Representative

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

This Authorization to Release Information is for:

_____

Patient's Name Date of Birth Medical Record Number

I authorize Oregon Trail Eye Center to release my records and any information requested to the following individuals:

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

4. _____ Relation to Patient:_____

_____ I DO NOT wish to disclose my information to anyone.

Authorization Regarding Messages
(*Please check any that apply*)

_____ I authorize you to leave a detailed message on my home or cell number regarding appointments

_____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

_____ I authorize you to leave a message with anyone who answers the phone

_____ Messages may only be left with _____

_____

Patient's Signature Date

_____

Parent/Legal Guardian/P.O.A. Signature Date