OREGON TRAIL EYE CENTER, PC

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

(Authorization to release patient's records from other health care provider)

TO: _____
(*health care provider)*

_____
(*address)*

_____
(*city, state, zip*)

_____
(*phone*)

_____
(*fax*)

RE: _____
(patient's name)

Patient's DOB: _____

You are hereby authorized and directed to release health care information related to the above named patient's present or past medical condition to:
Oregon Trail Eye Center, P.C.
329 West 40th Street, Scottsbluff, NE 69361
Phone: (308) 635-3911
Fax: (308) 635-3130
Email: medicalrecords@otecenter.org **(Preferred method for images)**

Information to be disclosed:

☐ All healthcare information from your facility, unless specifically limited below.

☐ Only the specific healthcare information requested.

_____

You are **not** authorized to release the following:

☐ Other Restrictions (specify): _____

Dates of Service To Be Released: From (Mo/D/Yr) _____ To (Mo/D/Yr)_____

For the purpose of: ____legal ____ insurance ____evaluation and treatment Other: _____

Revocation
This authorization is subject to revocation at any time by giving written notice to the Health Care Provider. The revocation is effective from the time it is received by the Health Care Provider and does not apply to actions taken by the Health Care Provider prior to that.

Expiration
If not revoked, this authorization terminates one year from the date of its execution, or on _____.

Acknowledgments
I understand that the information that is disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand I do not have to sign this authorization as a condition of receiving treatment from the Health Care Provider unless my treatment is research related or purpose of treatment is to generate information for a third party.

_____ _____ _____
Patient Name (Please Print) Date of Birth Witness

_____ _____ _____
Signature of Patient or Patient's Representative Relationship to Patient Date