OREGON TRAIL EYE CENTER, PC

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

(Authorization to release patient's records from our office)

I_____hereby authorize Oregon Trail Eye Center, P.C. to release my medical records to:

(Name) *(Specialty)*	*(Contact Phone Numbers)*
(Address)	*(Fax Number)*
City, State, Zip Code	*(Email Address - Preferred method for images)*

I intend for Oregon Trail Eye Center, P.C. to release the following information (Check One)

☐ Only healthcare information generated by Oregon Trail Eye Center, P.C.

Unless specified otherwise, we do not routinely release supplemental information such as visual field tests, fundus photographs, fluorescein angiograms, A- or B-scans, and X-rays. If you want us to release any of these items, please check the appropriate boxes. **PLEASE NOTE THAT RELEASE OF THESE ITEMS MAY INCUR A CHARGE FOR DUPLICATION**. Fees for duplication will be provided upon request, and are in conformance with provisions of MCA §50-16-526:

☐ Fundus photographs ☐ Fluorescein angiograms ☐ Visual Field tests ☐ OCT

☐ Other (please specify) _____

If there is specific information you **DO NOT** want us to release, please specify by checking the box:

☐ AIDS or HIV-related information

☐ Other (specify): _____

Dates of Service To Be Released: From (M/D/Yr)_____To (M/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 Privacy Officer as indicated in the Notice of Privacy Practices. The revocation is effective from the time it is received by Oregon Trail Eye Center, P.C. and does not apply to actions taken by Oregon Trail Eye Center, P.C. 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 Oregon Trail Eye Center, P.C. 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