



**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

Coos Bay Vision Center  
986 Central  
Coos Bay, OR 97420  
541.267.4224 telephone  
541.269.7357 fax  
Zendra Tams, Privacy Official

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Address \_\_\_\_\_

Patient Phone Number \_\_\_\_\_ Patient Acct # \_\_\_\_\_

I authorize \_\_\_\_\_ to release a copy of the medical information for  
(Name of Primary Health Care Provider)

Identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS

\_\_\_\_\_ to \_\_\_\_\_  
(Name of Patient) (Name and Address of Recipient)

The information will be used on my behalf for the following purpose(s):

- Medical records needed for continuity of care
- Last exam
- Other \_\_\_\_\_

If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted above. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, the consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

\_\_\_\_\_  
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

\_\_\_\_\_  
Representative Relationship to Patient

**Confidentiality Notice**

This message is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If you have received this information in error, please notify us immediately by telephone. Thank you.