VISION SOURCE®

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