AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize _____

to release the following records for continuation of care:

☐ - My medical information related to: ☐ -progress/chart notes ☐ -eye exams

☐-diagnostic imaging ☐ - labs/testing :_____

☐ - My medical-related information dated from_____ to _____

☐ - Other: _____

For :

Patient: _____**DOB**_____SSN_____

To the following party: **ONSIGHT EYE CENTER -705 SW BONNETT WAY STE 1150 BEND OR 97702**

Phone: 541-323-2020 Fax: 541-323-0744 E-Mail: osec2024@gmail.com

My Signature indicates that I authorize the disclosure of the above information and understand the following: I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____Date: _____

Print Name:_____

Or Signature of legal person/representative by law _____

Print Representative Name:_____

Relationship to patient: ☐ - Parent ☐ - Spouse ☐ - Guardian ☐ - Other_____