HILLSBORO EYE CLINIC, P.C.

HillsboroEyeClinic.com | 503-640-3708

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MEDICAL RECORDS RELEASE FORM

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____ SSN (last four digits): _____

Address: _____ City: _____ State:_____ Zip:_____

☐ Entity Requested to Release Information

Hillsboro Eye Clinic, P.C.

Purpose of request (who will be authorized to receive information)

I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Entity Requested to Receive Information:
(list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

City:_____ State: _____ Zip: _____

Phone/Fax: _____

Email: _____

Please include your email if you choose to receive records this way and see statement below.

* **SECURE COMMUNICATION - Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not use email as your preferred method of transfer if this is of concern to you.**

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Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; or, check only those items of the record to be disclosed:

- ☐ X -rays
- ☐ Office Notes
- ☐ Lab Results, Pathology Reports
- ☐ Financial history report (previous 3 years only)
- ☐ Record of HIV and communicable disease testing
- ☐ Record of mental health or substance abuse treatment
- ☐ Nursing home, home health, hospice, and other physician records
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient or Representative Signature: _____ Date: _____

You have the right to receive a copy of signed authorizations upon request.