SISKIYOU EYE CENTER

Authorization to Release Medical Records

Patient Information (please print)

Last Name:	First Name:	MI:	
Date of Birth:	Phone #:	Email:	
Street Address:	City:	State:	Zip:

I hereby authorize the doctor/facility (listed below) and its affiliates to release my personal health information to Siskiyou Eye Center: 541-488-5081 fax Ashland, OR 530-842-5839 fax Yreka, CA

Name of Doctor and/or Facility: _____

Address: _____

Phone #: _____ **Fax #:** _____

Information to be Released:

☐ Entire Medical Record ☐ History & Physical ☐ Operative Report ☐ Lab Reports
☐ Operative Report ☐ Discharge Summary ☐ Radiology Reports ☐ Billing
☐ Other (specify) _____
For the following date(s) of service: ____/____/____ through ____/____/____

I understand that information in response to this request may be related to testing of AIDS/HIV, whether the result is negative or positive, treatment for drug and alcohol use/abuse, and psychiatric care or treatment.

AIDS/HIV Information: Please initial. _____ Yes, disclose _____ No, do not disclose
Drug or Alcohol use/abuse: Please initial. _____ Yes, disclose _____ No, do not disclose
Psychiatric Care/Treatment: Please initial. _____ Yes, disclose _____ No, do not disclose

Purpose of the Requested Information

☐ Further medical care ☐ Payment of insurance claim ☐ Legal investigation
☐ Application for insurance ☐ Vocational rehabilitation evaluation ☐ Personal
☐ Disability determination ☐ Other (specify) _____

Authorization Expires

I understand that this authorization is valid for one (1) year unless otherwise stated below or revoked through written notice to Siskiyou Eye Center. Alternate date (if not one year): _____.

Authorization

This authorization covers only treatment prior to the date recorded below. I understand that I may revoke this authorization at any time with a written request to the Health Information Management Department of the above-named person/facility, except to the extent that action has been taken in reliance on this authorization. I understand that I am financially responsible for any charges associated with processing a request and producing requested records as permitted by applicable state and federal laws. This form has been fully explained and I certify that I understand its contents.

Patient Signature: _____ **Date:** _____
(If signed by a person other than the patient, state relationship and authorization to do so).

Authorized Signature: _____ **Relationship:** _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal Authority: ☐ Legal ☐ Legal Guardian ☐ Next of kin of deceased