

Child Eye Care Associates, LLC

9735 SW Shady Lane, Suite 203, Tigard, Oregon 97223
Office (503) 635-4436 Fax (503) 635-7356

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name (if applicable): _____ Social Security #: _____

I request and authorize:

Physician Name: _____

Practice: _____

Address: _____

Tel: _____ Fax: _____

to release healthcare information of the patient named above to **Child Eye Care Associates, LLC, 9735 SW Shady Lane, Suite 203, Tigard, OR 97223**, for the purpose of reviewing their records.

This request and authorization applies to:

Healthcare information relating to:

Eye care Other _____

- i) This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- ii) This authorization shall be in force and effect until ___/___/___ at which time this authorization expires.
OR
 This authorization shall expires ninety days after it is signed
- iii) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- iv) I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- v) I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient's Signature: _____ Date: _____

Patient Representative's Signature: _____ Date: _____

Legal Name of patient's representative: _____ Relation to patient: _____