Child Eye Care Associates, LLC
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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 **Child Eye Care Associates, LLC, 9735 SW Shady Lane, Suite 203, Tigard, OR 97223** to release healthcare information of the patient named above to:

Physicians Name:____

Practice:____

Address: ____

____

Tel: __________________________________ Fax:__________________________________

For the purpose of:

☐ My personal records (a fee may be incurred)

☐ Sharing with other providers (no charge is incurred if sent directly to the provider)

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:______________