



Authorization For Release of Identifying Health Information

Coos Bay Vision Center
986 Central
Coos Bay, OR 97420
541.267.4224
Zendra Tams, Privacy Official

Patient Name: _____

Patient Address: _____

Patient Phone Number (____) _____

I authorize Coos Bay Vision Center, Inc. to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, genetic information, and HIV infection or AIDS) under the following conditions:

Specific info to be released: _____

Reason for the release: _____

Name & address of recipient: _____

Termination date for authorization: ___ / ___ / _____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the Notice of Privacy Practices.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Signature: _____

Date: ___ / ___ / _____

If you are signing as a personal representative of the patient, please indicate your relationship

Representative: _____

Relationship to Patient: _____