Authorization To Disclose **Medical Records** Request

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

Provider/Entity: _____
Address: _____
City / State / Zip: _____
Secure email: _____

Fax: _____

Information Requested:

I _____ (patient full name) authorize the above-named provider/entity to release the following designated medical information.

___ Copy of complete medical records including results of diagnostic testing
___ Medications and active problems list
___ Other information_____

Release Authorized to:

Coos Bay Vision Center, Inc.
986 Central Avenue PO Box 329
Coos Bay, OR, 97420
Fax: (541) 269-7357

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. IF I AM SIGNING FOR A MINOR, MY SIGNATURE ATTESTS THAT I HAVE LEGAL AUTHORITY OVER MEDICAL DECISIONS FOR THE DESIGNATED MINOR.

_____
Print Name/Date of Birth

Date _____ / _____ / _____

Patient or legally authorized individual
signature_____

_____
Printed name if signed on behalf of the patient designate parent or guardian (if signing for minor)