AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL RECORDS

(Complete every section or this form may be returned to you for completion)

Identity

Patient Name:_____ Date of Birth:_____

Address:_____ Social Security #:_____

_____ Phone #:(____)_____

Release Medical Records **FROM** Pacific Vision Medical Center **TO**:

Name:_____

Address:_____ FAX Number:(____)_____

_____ Phone Number:(____)_____

Important – If your record contains information regarding any of the following and you indicate "No", we will NOT be able to forward your records to anyone other than you (*patient named above).*

( ) No HIV (AIDS virus) ( ) No Sexually transmitted diseases

( ) No Psychiatric disorders/mental health ( ) No Drug and/or alcohol use

Note: The records provided will be those that are relevant to your future eye care. Should you want a copy of your entire record, there may be additional charges.

_____ _____

Date Time Signature(Patient or legal representative)

_____ _____

Printed name if legal representative Relationship

Mail with payment to: Dustin Bodman, OD, Custodian
586 5th Street, Suite 300
Brookings, OR 97415