Bala Ambati, MD
Physician & Surgeon
Robin Bautista, OD
Optometric Physician
Scott A. Cherne, MD
Physician & Surgeon

Pacific ClearVision INSTITUTE

1125 Darlene Lane
Eugene, OR 97401
Phone: 541.343.5000
Fax: 541.344.9478

Omer Gal, MD
Physician & Surgeon
Bradley J. Lorenzen, OD
Optometric Physician

Authorization to Disclose Medical Records

(Name of patient) _____ (Date of birth) _____ (Phone number) _____

(Street address) _____ (City) _____ (State) _____ (Zip) _____

Information released:

From: _____ To: _____

_____ _____

_____ _____

I am giving my consent to allow this information to be used on my behalf.

It is duly noted that the medical records department of this office has at least thirty (30) days to complete this request. I understand that there may be charges associated with providing these records to be paid in full prior to mailing records (CFR 164.524)

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

	Clinician Office Chart Notes for: All (Last two years of records unless specified)
	Surgery report (Including cataract surgery, anterior segment, retina, glaucoma, and laser procedures)
	Laser Vision Correction Reports (Including LASIK/LASEK/PRK/Other)
	Anterior Segment Photographs / Fundus Photographs / Fluororesin Angiograms
	Corneal Topography / Endothelial Cell Count Photos
	Laboratory Reports / Pathology Reports
	Diagnostic Imaging Reports
	Professional Letters or communications to other clinicians
	Billing Statement
	HIV/AIDS related records **(MUST BE INITIALED TO BE INCLUDED IN OTHER DOCUMENTS)**
	Mental Health Information **(MUST BE INITIALED TO BE INCLUDED IN OTHER DOCUMENTS)**
	Genetic Testing Information **(MUST BE INITIALED TO BE INCLUDED IN OTHER DOCUMENTS)**
	Drug / Alcohol Diagnosis, Treatment, Referral Information (Federal Regulation 42 CFR Part 2 applies)
	PLEASE SEND ENTIRE MEDICAL RECORD (All information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all charges associated with providing these records prior to mailing record.
	This authorization is **LIMITED TO THE FOLLOWING TREATMENT:**
	This authorization is **LIMITED TO THE FOLLOWING TIME PERIOD:**
	This authorization is **LIMITED TO THE WORKERS COMPENSATION CLAIM FOR INJURIES OF:**
	DATE RANGE SPECIFIED: Claim number (if known)
	Other Requested Medical Records

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. I understand that after PCVI discloses my medical information, the new health care provider may disclose my information for the purpose of treatment, payment, or operations.

If you wish to revoke your authorization, you must send a written notice, directed to the HIPAA Contact, c/o Pacific ClearVision Institute, at the office address, stating your authorization is revoked. Unless revoked earlier, this consent will expire 180 days from the date of signing, or remain in effect for the period reasonably needed to complete the request.

Signature of patient, or person authorized by law _____ Relationship to patient _____ Date _____