

Patient Name Maiden Name SS#

Date of Birth Home Phone Cell/Work

Address City/State/Zip

Email Address:

**A) I hereby authorize records FROM**:

Name Retina Northwest, P.C.

**B) To be released TO:**

Name

Address 2525 NW Lovejoy #300

Address

City/State/Zip\_\_Portland, OR 97210

City/State/Zip\_

Phone# 503-274-2121 Fax# 866-843-7990

Phone# FAX#

**C) For the purpose of:**

Litigation

Insurance

Disability/SSI Work Comp

Date Range to

Physician Office Notes Cardiology/EKG Reports

Immunizations Lab/Path Reports

Self/Personal Copy Other

Operative/Procedure Reports Radiology/XRay/MRI Reports

Continuity of Care Transfer of Care

(Permanently Leaving)

Other

Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization . I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re- disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insu rance company when the law provides my insurer with the right to contest a claim under my policy.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

**\*\*Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: (Expiration date of authorization)

**\*PLEASE READ** Fee Information*:* **Retina Northwest, PC** contracts with DataFile Technologies to copy and provide all medical records requested from our office. DataFile Technologies reserves the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to patient, DataFile Technologies may transfer a minimal portion of your records as a courtesy.

DataFile Technologies: 816-437-9134 2016 Authorization Form