Lifetime Eye Care Inc.
4765 Village Plaza Loop, Suite 100
Eugene, Oregon 97401
Phone 541.342.3100 Fax 541.342.6153
www.LifetimeEyeCare.net

Lifetime Eye Care

Authorization for Release of Information

Patient Name: _____ DOB: _____

By law, we are not permitted to release any information about you to anyone other than your referring and/or consulting physician(s) and your health insurance company without your written consent relating to your health care. **Please list all other persons that our office may speak with regarding your care.** If there are family members, i.e. spouse, children, or friend you would like to designate to receive information or be able to inquire regarding your medical status and treatment, their names and relationship MUST be entered on the form. By listing these names you are providing our office with permission to discuss your medical status when they contact us on your behalf.

Our office will also allow the individuals listed below to pick up items from our office, such as your medical records. Again, to pick up your medical records, optical materials, or to discuss financial or insurance information on your behalf, **we must have a signed authorization from you stating your permission to do so.**

1. _____ _____
   Name (Please Print) Relationship
2. _____ _____
   Name (Please Print) Relationship
3. _____ _____
   Name (Please Print) Relationship
4. _____ _____
   Name (Please Print) Relationship
5. _____ _____
   Name (Please Print) Relationship

*I hereby authorize Lifetime Eye Care to release **health information and received information** identifying me or my child, including if applicable, information about HIV infection or AIDS, information about substance abuse, and information about mental health. This consent is subject to revocation at any time by the signed party. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. This authorization will expire on the earlier of _____ (date), or 180 days from the date of signing or the end of the period reasonably needed to complete the request.*

Patient/Parent/Guardian Signature: _____

Date of authorization: _____