Lifetime Eye Care
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 HEALTH INFORMATION

Print Patient Name:_____ **DOB:**_____

Requesting Records From:

Dr./Clinic: _____
Address: _____
City, State, Zip_____
Phone#: _____
Fax#: _____

REQUESTING

☐ Glasses Rx ☐ Contact Lens Rx
☐ Last Exam ☐ Treatment Notes
☐ All records last 3 years
☐ Include HIV/AIDS related records
☐ Drug/alcohol related records

Sending Records To:

Dr./Clinic: Lifetime Eye Care
Address: 4765 Village Plaza Loop, Suite 100
City, State, Zip Eugene, OR 97401
Phone#: 541-342-3100
Fax#: 541-342-6153

I hereby authorize the professional office of my doctor named above to **release health information or receive health information** identifying me or my child (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

If you sign this authorization, you can revoke it at any time. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, please send us a written or electronic note telling us that your authorization is revoked. This authorization will expire on the earlier of _____ (date) 180 days from the date of signing or the end of the period reasonably needed to complete the disclosure for the above-described purpose

I have read and understand this form. I am signing voluntarily. I authorize the disclosure of my health information as described in this form.

****Restrictions-**Initial and complete if applicable:

_____This authorization is limited to the following time period_____

_____This authorization is limited to the following treatment: _____

Patient/Parent Signature:_____ Date of authorization:_____