301 Cherry Heights Rd
The Dalles OR 97058
541-296-1101 FAX 541-298-1538

2025 Cascade Avenue
Hood River OR 97031
541-386-2402 FAX 541-308-0293

CASCADE EYE CENTER

JOHN D. WILLER, D.O.
Board Certified Ophthalmologist
DALE BRICKER, O.D.
JANESSA HARTMAN, O.D.
B. JEFFREY PULK, O.D., F.A.A.O.
Optometric Physicians

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____
Patient's First Name (Print) Middle Name Last Name Prior Last Name (if applicable

_____
Address City State Zipcode

_____ _____ _____
Daytime Phone # Patient's Date of Birth Date of Request

By signing below, I authorize Cascade Eye Center to release or obtain my medical information, and/or other information protected under the HIPAA privacy law

❑ **To** the following person, clinic, or provider: ❑ **From** the following person, clinic, or provider:

_____
Name / Clinic / Facility

_____
Address City State Zipcode

_____ _____
Telephone # FAX #

Purpose of Request:

❑ Changing Eyecare Providers
❑ Consultation/Second Opinion
❑ Continuing Care
❑ Worker's Compensation Claim
❑ Legal
❑ Personal Use
❑ Insurance
❑ Other _____

Information to be Released:

❑ All Eyecare Records
❑ Last Exam Notes/Rx
❑ Other _____

1. I understand that this authorization will expire 1 year (12 months) after the date I have signed this form, or when a minor reaches the age of majority, or as of _____ (whichever date is soonest).
2. I understand I may revoke this authorization at any time by notifying Cascade Eye Center in writing.
3. I understand I may see and copy the information described on this form if I request a copy.
4. I understand I may get a copy of this form after I sign it.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Parent/Legal Guardian/Authorized Person Date Relationship to Patient

Notice to Person or Agency receiving this information: This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Form version 12/2/2019