TUALATINEYE ASSOCIATES

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize the entity listed below to release confidential health information about me by releasing a copy of my medical records, or summary, or narrative of my protected health information. This release is valid for one year from date of signature. Please print clearly.

PATIENT INFORMATION:

First Name: _____ Last Name _____

DOB: ____/____/_____

NAME OF PRACTICE/DOCTOR FROM WHO RECORDS ARE REQUESTED:

Practice/Doctor's Name: _____

Address:_____

Phone: _____ Fax: _____

PLEASE RELEASE THE PROTECTED HEALTH INFORMATION TO:

Tualatin Eye Associates
18801 SW Boones Ferry Rd.
Tualatin, OR 97062
Phone: 503-692-3500
Fax: 503-692-3500
Email: admin@tualatineye.com

Patient or Guardian Signature:_____ Date: _____

Patient or Guardian (print):_____

WARNING: The medical information that may be contained in this transmission is CONFIDENTIAL AND PRIVILEGED. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate confidential medical information. If the reader of this warning is not the intended recipient or the intended recipient's agent, you are hereby notified that you have received this transmission in error, please notify us immediately at the telephone number listed above, and destroy or delete this communication.