Oregon Retina, LLP

Protected Health Information Release

I _____, give permission for the following medical/health records about me to be released by Oregon Retina, LLP and its authorized agents/contractors to the persons/organizations and for the purposes described below:

• Specific Description of medical/health information to be provided *(Additional approval required for certain records)

_____

_____

• OREGON RETINA, LLP can also release drug/alcohol treatment/referral records: Yes: __ No: __

• OREGON RETINA, LLP can also release HIV/AIDS test/treatment records: Yes: __ No: __

• OREGON RETINA, LLP Can also release mental health information

discovered during encounters: Yes: __ No: __

• Oregon Retina, LLP can release my medical/health information to the following persons/organizations:

_____

_____

• My medical/health records will be used for the following purposes:

_____

For medical/health records, I have given permission to be disclosed, OREGON RETINA, LLP can talk to, or give copies of my medical/health records to any of the persons/organizations I have permitted and can give this information by paper, fax, computer, or electronic copies of those records. YOU DO NOT HAVE TO SIGN THIS FORM. I understand that my eligibility for benefits or services from Oregon Retina, LLP will not be affected if I do not sign this form.

• I will get a copy of this form after I sign it. I can ask OREGON RETINA, LLP to let me see a copy of the information they are sending after I sign this form.

• This permission is good for 12 months from the date I sign this form, unless I take back my permission sooner.

• You have the right to withdraw your permission at any time. You cannot take back information that has been given to other persons/organizations before you take back your permission and it will not affect any actions taken before you take back your permission.

• To take back your permission to let us give your medical/health records to other persons/organizations, you can write OREGON RETINA, LLP, or the persons/organizations that you have said we can give your information to. I understand that the person or organization that I have given permission to get my medical/health information may not be required by law to protect that information under federal or state law or regulations.

• Ask OREGON RETINA, LLP to explain if you have questions about what information was given to any person or organization.

Signature of Person: _____ Date: _____

Or Authorized Representative: _____ Relationship_____ Date: _____

This authorization was developed to comply with the provisions regarding disclosure of medical/health information under P. L. 104-191 ("HIPAA"); 45 Code of Federal Regulations parts 160 and 164; 42 U.S. Code Section 290dd-2; 42 CFR part 2.31; 38 U.S. Code section 7332 and T.C.A § 68-10-113.