Child Eye Care Associates, LLC
9735 SW Shady Lane, Suite 203, Tigard, Oregon 97223
Office (503) 635-4436 Fax (503) 635-7356

Shawn Goodman, MD David T Wheeler, MD Julie S Yu, MD Sophia Fang, MD

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

Previous Name (if applicable):_____Social Security #:_____

I request and authorize:

Physician Name:_____

Practice:_____

Address: _____

_____

Tel: _____ Fax:_____

to release healthcare information of the patient named above to **Child Eye Care Associates, LLC, 9735 SW Shady Lane, Suite 203, Tigard, OR 97223,** for the purpose of reviewing their records.

This request and authorization applies to:

Healthcare information relating to:

☐ Eye care ☐ Other _____

i) This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

ii) ☐ This authorization shall be in force and effect until ___/____/_____ at which time this authorization expires.

OR

☐ This authorization shall expires ninety days after it is signed

iii) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

iv) I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

v) I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient's Signature: _____Date:_____

Patient Representative's Signature:_____Date:_____

Legal Name of patient's representative:_____Relation to patient:_____