1226 NE 7th Street
Grants Pass, OR 97526
Phone: 541-476-6636
Fax: 541-476-6690

Cascade EyeCare Center

Physicians & Surgeons • Ophthalmology

Douglas R. Merritt, M.D.
Rodney D. Leavitt, M.D.
Matthew R. Guymon, D.O.
Matthew D. Fullmer, D.O.

MEDICAL RECORDS RELEASE

Date of Request _____

Patient Name _____ Date _____

I authorize the custodian of records to disclose/release the following information* (check all that apply):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ Billing records
- ☐ X-ray/radiology records
- ☐ Pharmacy/prescription records
- ☐ Surgery records
- ☐ Other (describe specifically) _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information.*

Please send the records ☐ to / ☐ from: **Cascade EyeCare Center, PC**
1226 NE 7th Street
Grants Pass, OR 97526.

☐ **Records may be faxed to 541-476-6690.**

Please send the records ☐ to / ☐ from: _____

_____

_____

☐ **Records may be faxed to** _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

☐ Patient ☐ Parent/Guardian ☐ Guarantor

Signed _____ Date _____

Printed name of patient representative _____
Representative's authority to sign for patient (i.e. parent, guardian, power of attorney)

_____