Landon Karren, DO **Bruce Madsen, MD**
Erika Bury, OD **David Wolf, OD**

AUTHORIZATION TO RELEASE INFORMATION

Date: _____

Patient: _____

_____
Social Security No. Date of Birth

To: _____

_____
Address Phone # Fax #

For the purpose of: _____

I hereby authorize and request that you release the complete medical records (including mental health, social history, and HIV/ STD) in your possession. You have the right to revoke this authorization. This request must be submitted in writing.

_____
Signature of Patient or Legal Guardian

_____
Witness

20015 SW Pacific Hwy. #150
Sherwood, OR 97140

700 Deborah Rd. #150
Newberg, OR 97132

Phone: 503-610-1025
Fax: 503-610-1596

(This authorization is valid for 12 months after signing)

OREGON EYE
PHYSICIANS & SURGEONS

RELEASE OF INFORMATION

I _____acknowledge that the Oregon Eye Physicians and Surgeons can authorize and release my health information only with my consent.

I hereby give Oregon Eye Physicians and Surgeons consent to release my health information, to the persons' listed below. I acknowledge that this release of information only consists of family and friends approved by me to only be released over the phone.

I opt out of all if any ROI to the persons' below pertaining to HIV/STD. _____
I allow all if any ROI to the persons' below pertaining to HIV/STD. _____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

_____
Signature of Patient or Legal Guardian Date

_____
Witness

(This authorization is valid for 12 months after signing)