MEIER
EYE CLINIC

DOUGLAS MEIER, MD
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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize _____

Phone:_____ Fax:_____

To release confidential medical information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, prognosis, including x-ray, correspondence and/or medical records by means of mail, fax or other electronic methods. **Note: *Information and records regarding treatment of HIV have special rules that require specific authorization.***

This authorization is:

- ○ Unlimited (all records, excluding HIV diagnosis/treatment)
- ○ Limited to the following medical information_____
- ○ Immunizations only
- ○ For a specific time period from _____to _____

I also consent to the specific release of tests for antibodies to HIV_____initials

To: Meier Eye Clinic, 2535 SE Harrison St, Milwuakie OR 97222 Phone: 503-387-6241 Fax: 503-387-6244

Restrictions: Permission for further use and disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of a facsimile is of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of patient or legal guardian_____ Relationship to patient_____

Patient Name Printed_____ Date _____