WESTON
EYE CENTER

Jon-Marc Weston, MD, FACS
Steve Tronnes, OD, FAAO

2435 NW Kline St.
Roseburg, OR 97471

541-672-2020
541-673-8084 fax
1-800-842-2030
westoneyecenter.com

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION.

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize: _____

_____

_____

To Disclose to: Weston Eye Center

2435 NW Kline St.

Roseburg, OR 97471

Records and information pertaining to:

Patient: _____ DOB:_____

Address:_____ Phone Number:_____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless otherwise stated.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the Requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Records: **{ } Medical/Eye History Information** initial_____

{ } Other Health Information initial_____

Date:_____ Signature:_____