Authorization for Release of Medical Information

Jonathan D. Jahnke, M.D.
Physician and Surgeon
Ophthalmologist
VALLEY EYE & LASER

Patient Name:_____ DOB: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City, State, Zip:

_____

The above listed patient authorizes the following facility to disclose/receive medical information:

☐ **Disclose** ▢ **Receive**

Valley Eye Center, Jonathan D. Jahnke, MD

307 E Hancock St
Newberg, OR 97132

Phone: 503.538.2010
Fax: 503.554.9549

☐ **Disclose** ▢ **Receive**

Facility/Provider's Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Information will only include records originating in this office from the past 2 years unless otherwise requested:

☐ Physician notes and records
☐ Exam and refraction information
☐ Contact lens information
☐ Other (please specify): _____
☐ Diagnostic testing
☐ Visual field testing
☐ Operative reports

_____

Signature **Date**

This authorization will remain in effect for one year from the signature date above unless an alternate date is specified here: _____. You may revoke authorization at any time; however, this does not apply to previously released information.

**Please note: a copy fee may be charge for medical records*