Pediatric Ophthalmology & Adult Strabismus
Pittsburgh, Pennsylvania

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Pediatric Ophthalmology & Adult Strabismus to release information from the record of: _____ (Patient Name); _____ (Birth Date) as described below to:

Name of Facility/Person: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Fax: _____

Fill out completely to properly identity the records to be released.

1. Date of service: _____

2. Information to be released:

□Emergency Department Report	□Radiology Report	□Operative Report	□Consultation Report
□Physician Orders/Progress Notes	□In Patient/Out Patient exam		□All listed

I understand the following:

- That this Authorization is in effect for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization any time by sending a written request to the entity/person I authorized above to release the information.

Please be aware that health care facilities are authorized by Pennsylvania State & Government Regulations to charge for the reproduction of medical records and that the charges may be associated with this request.

A Fee of $27.00 is expected for Processing

Additional Patient Rights and Responsibilities

I understand the following:

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable las may prohibit re-disclosure of these records. I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) Pediatric Ophthalmology & Adult Strabismus and its staff/employees have no responsibility or liability as a result of redisclosure and (2) such information would no longer be protected under the Privacy Rule.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of a claim
- Pediatric Ophthalmology & Adult Strabismus cannot require me to sign the Authorization in order to receive treatment.
- I am entitled to a copy of this completed Authorization form.

_____ _____

Printed Name of Authorized Representative **Date**

_____ _____

Signature of Authorized Representative **Date of Signature**

C: admin/office docs/authorization for release of records from POS 041116

Business Office
(direct all correspondence to)
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www.eyemdsforkids.com

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Cranberry Township, PA 16066
(724) 772-3388 • FAX: (724) 772-7021

South Office:
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Washington, PA 15301
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