Pediatric Ophthalmology & Adult Strabismus
Pittsburgh, Pennsylvania

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize_____ to release information from the record of:_____;_____ as described below to:
(Patient Name) (Birth Date)

Name of Facility/Person: Pediatric Ophthalmology & Adult Strabismus
Address: 124 Graham Park Drive Suite 300 City: Cranberry Twp. State: PA Zip: 16066
Phone: 724-772-3388 Fax: 724-772-7021

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.

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 records release041116