Pennsylvania Retina Specialists, PC

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Date: _____

Patient's Name: _____ DOB: _____/_____/_____

Address: _____

Information Requested: Most recent records from _____/_____/_____ to _____/_____/_____

I hereby authorize Pennsylvania Retina Specialists to (check one)

☐ Obtain from the following ☐ Release to the following

Name: _____

Address: _____

_____

Phone: _____FAX# _____

I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)

☐ Mental Health (including psychotherapy notes)

☐ HIV & STD related information (AIDS related testing)

Duration: This authorization shall become effective immediately and shall remain in effect until _____/_____/_____ (date) or for one year.

Revocation: My written revocation will be effective upon receipt, but will not be effective to the extent the requestor or others have acted in reliance upon this authorization.

Re-disclosure: I understand the requestor may not lawfully further use or disclose the health information unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

This information is requested for the following purpose (check all that apply):
☐ Medical ☐ Legal ☐ Personal ☐ Other: _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print Name Relationship to Patient if Legal Representative

Fax# (717)761-5604