LAUREL
EYE CLINIC
**50 Waterford Pike**
**Brookville, PA 15825**
**PHONE: 814-849-8344**
**FAX: 814-849-7130**

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____ Phone Number _____

I hereby authorize Laurel Eye Clinic to ☐ RELEASE MY RECORDS TO or ☐ REQUEST MY RECORDS FROM:

Name of Facility/Person _____

Address: _____

Phone: _____ Fax: _____

Reason for the release:

☐ Continued Care ☐ Personal ☐ Legal ☐ Insurance ☐ Other Specified_____

**Dates of Treatment Requested -- MUST BE COMPLETED, IF NOTHING IS MARKED ONLY LAST 2 YEARS WILL BE SENT.**

☐ Most Recent (last 2 years) ☐ All Visits ☐ **Specific Dates:** _____

**Information to Release or Request:**

☐ Clinical Progress Notes ☐ Operative Reports ☐ Medication Records

☐ Complete Record ☐ Testing ☐ Fluorescein Angiograms

☐ Laboratory Reports ☐ Consults ☐Other _____

☐ **Re-Disclosure of Records from Physicians or Health Care Professionals/Institutions Name or Institution:**

_____

**Reports of HIV, Behavioral Health, and Drug and Alcohol treatment contained in the parts of the record(s) indicated above will be released through this Authorization, unless I request otherwise by checking here: ☐**

I understand the following:

- That my health record(s) will not be released or obtained by LEC unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization.)
- That the release of my/my child's health record(s) will be for the purpose stated on this form, and only those items checked off will be released.
- That the health record(s) released by LEC may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) LEC and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- That this Authorization is in effect for the period of 90 days from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this Authorization form at any time by sending a written request to the Laurel Eye Clinic, 50 Waterford Pike, Brookville, Pa. 15825, Phone 800-494-2020, fax 814-849-7130.
- That my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- That LEC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization or not.
- That I am entitled to a copy of this completed Authorization form.
- I authorize the use of fax for the release or disclosure of the information described above. A photocopy of this consent will have the same effect as the original.

☐ Request was made verbally by the patient or a treating provider for continued care Documented by:_____
Patients identity was verified – dob, address, phone number

Patient Signature _____ Date _____ Witness _____

Signature of Legal Guardian/Power of Attorney _____ Date _____ Witness _____

*Patient (is a minor_____ years of age) or (is unable to give consent because)* _____