# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Print Patient's Full Name: _____ _____ _____
FIRST MI LAST

Patient's SS Number: _____

Patient's Date of Birth: _____

I Hereby Authorize: **EYES OF YORK CATARACT AND LASER CENTER**

To Release Records To: _____
_____
_____
(Complete name and address of recipient)

To Request Records From: _____
_____
_____
(Complete name and address of holder of records)

**I AUTHORIZE MY HEALTHCARE PROVIDER AND/OR ADMINISTRATIVE OR CLINICAL STAFF TO DISCLOSE OR RECEIVE THE FOLLOWING RECORDS (CHECK ALL THAT APPLY):**

Date of Service _____

- ❑ Progress/Office Notes
- ❑ Complete Medical Record
- ❑ Preoperative Medical History Summary (attached)
- ❑ Ophthalmic Tests _____
- ❑ Laboratory Report _____
- ❑ Other _____

## PLEASE CHECK REASON FOR RELEASE:

- ❑ Continuing Care
- ❑ Patient Request
- ❑ Transfer of Care
- ❑ Insurance other than your healthcare plan
- ❑ Other _____
(Please Specify)

Expiration Date _____ (Six months from the date signed)

**RIGHT NOT TO SIGN.** You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by Eyes of York, except in the case of healthcare that is solely for the purpose of creating healthcare information for disclosure to a third party (i.e., a pre-employment physical) or research-related care.

**RIGHT TO REVOKE.** You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address: EYES OF YORK, Attention Privacy Officer, 1880 Kenneth Road Suite 1, York PA 17404

**48 HOUR POLICY!! Once you sign authorization, Eyes of York makes an effort to disclose medical records to the recipient within 48 hours, however it can take up to 30 days.**

***Record copying and/or mailing fees in the amount of $_____ will be billed to Patient listed on this form. This amount must be paid within 10 days of release, otherwise Collection Procedures will occur.***

**Patient made aware of this on _____/_____/_____ by Phone/ Mail/ In Person.**

_____ _____
Signature of Responsible Party Date

_____ _____
Eyes of York Authorized Physician Signature Date