



# 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: \_\_\_\_\_ as described below to:  
(Patient Name) (Birth Date)

Name of Facility/Person: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

1. Date of service (when patient was seen in office/OR) \_\_\_\_\_

2. Information to be released:

<input type="checkbox"/> Emergency Department Report	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Consultation Report
<input type="checkbox"/> Physician Orders/Progress Notes	<input type="checkbox"/> In Patient/Out Patient exam		

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 \$10.00 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 laws 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 re-disclosure 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 101016

**Business Office**  
(direct all correspondence to)  
124 Graham Park Drive, Suite 300 • Cranberry Township, PA 16066  
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