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Jefferson Hills, PA 15025
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FORM TO RECEIVE RECORDS

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name ________________________________ Telephone Number ____________________
DOB ________________________
Address ____
City _______________________________ State __________________ Zip Code ______________

I authorize _________________________ to release my Medical/Vision information identifying me (including, if applicable, information about HIV infection or AIDS, substance abuse treatment and mental health services) to the following:

Pittsburgh Eye Institute 1675 State Route 51 Jefferson Hills, PA 15025

Please include: Visual Field Results, Contact Lens Specifications, K Readings, A Scan Measurements & Implant Powers, Operative Notes, Diagnosis

When your health/vision information is disclosed, as you have requested in this authorization, the recipient may have no legal duty to protect its confidentiality and may disclose the information as he/she wishes, unless state or federal law prohibits.

It is your decision whether or not to sign this form, however, our office cannot fulfill your request to transfer your medical records without completion of this form.

If you sign this form you may revoke it at any time. The only exception to your right to revoke is if we have already acted upon your request and forwarded your health/vision records to the person or facility you have requested above. If you wish to revoke this authorization it must be done in writing.

I HAVE READ & UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH/VISION INFORMATION AS DESCRIBED IN THIS FORM.

____ _____________________________
Patient Signature **Date**

____
Name (Printed)

IF YOU ARE SIGNING AS A PERSONAL REPRESENTATIVE OF THE PATIENT, PLEASE DESCRIBE YOUR RELATIONSHIP TO THE PATIENT & YOUR SOURCE OF AUTHORITY TO SIGN THIS FORM (PLEASE PROVIDE COPY OF POWER OF ATTORNEY/AUTHORIZATION).

____ _____________________________
(Relationship to Patient) **Date**

____
(Please Print Your Name)

____
(Source of Authorization)