EYE ASSOCIATES OF LANCASTER, LTD.
1254 LITITZ PIKE
LANCASTER, PA. 17601-4340
Phone: (717) 397-4724 Fax: (717) 397-6687

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I, _____, HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION AS LISTED BELOW.

Patient's name:_____ **Date of Birth:**_____

Address: _____

Telephone: _____

Provider or facility authorized to release information: _____

Person or entity authorized to receive information: _____

_____

Dates of Service: ☐ All ☐ Specific Dates of Service: _____

Description of information: ☐ Entire Record ☐ Other (Please list) _____

_____

Purpose of Release of Information: _____

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1. This authorization will expire: ☐ Date:_____ ☐ Event:_____
   Unless otherwise specified, this authorization will expire I year after the date of this request.
2. I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or entity that is authorized to receive these records. I understand that revocation will not have any effect on actions taken prior to any revocation and will not apply to information that has already been released in response to this authorization.
3. This authorization is voluntary. I can refuse to sign this authorization.
4. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.
5. I understand that this information may be re-released by the recipient and no longer protected.
6. By signing below, I certify that I understand the nature of this Release.
7. I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
8. If mental health records are being released as permitted by the Mental Health Procedures Act, I understand that I have a right, subject to 55 Pa. Code § 5100.33, to inspect the material to be released.
9. If AIDS or HIV-related information is being released, this information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.
10. **By signing below, I authorize the release of the medical information requested and specifically waive the confidentiality protection afforded by Pennsylvania statutory law for the Special Records indicated above.**

    This waiver is applicable only to this request and is not meant to be a general waiver.

_____ _____
Signature of Patient or Patient's Representative/Guardian **Date**

Printed Name of Patient's Representative: _____

Relationship to the Patient_____