



**Pediatric
Ophthalmology
& Adult Strabismus**
Pittsburgh, Pennsylvania

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release information from the record of: _____ as described below to:

(Patient Name) (Birth Date)

Name of Facility/Person: Pediatric Ophthalmology & Adult Strabismus
Address: 124 Graham Park Drive Suite 300 City: Cranberry Twp. State: PA Zip: 16066
Phone: 724-772-3388 Fax: 724-772-7021

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

1. Date of service (when patient was seen in the 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.

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 law 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 redisclosure 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 records release083116

Business Office

(direct all correspondence to)
124 Graham Park Drive, Suite 300 • Cranberry Township, PA 16066
Phone (724) 772-3388 • FAX: (724) 772-7021
www.yemdsforkids.com



North Office:

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South Office:

Meadows Professional Center
1385 Washington Road (Rt. 19)
Washington, PA 15301
(724) 772-3388 • FAX: (724) 772-7021

East Office:

Old William Penn Professional Bldg., Suite 2
4750 Old William Penn Highway
Murrysville, PA 15668
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