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## Diplomates of the American Boards of Ophthalmology and Optometry

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## AUTHORIZATION FOR USE OR RELEASE OF MEDICAL RECORDS

2108 Harrisburg Pike, Suite 100 Lancaster, PA 17604-Fax: 717-974-9669  SEND MY INFORMATION TO:    RECEIVE MY INFORMATION FROM     Name:	Name:	DOB:	Phone#:
2108 Harrisburg Pike, Suite 100 Lancaster, PA 17604-Fax: 717-974-9669  SEND MY INFORMATION TO:    RECEIVE MY INFORMATION FROM     Name:	Address:	City/State: _	Zip:
Name:	. AUTHORIZES:	2108 Harrisburg Pik	e, Suite 100
Address:	SEND MY INFORMATIO	N TO:	ECEIVE MY INFORMATION FROM:
Fax #:	Name:	Nan Nan	ne:
B. INFORMATION TO BE DISCLOSED:    Entire medical record   Specific records/information as follows:   Dates of information to be disclosed: From to	Address:	Add	lress:
B. INFORMATION TO BE DISCLOSED:    Entire medical record     Specific records/information as follows:	Fax #:	Fax	#:
□ Entire medical record □ Specific records/information as follows: □ Dates of information to be disclosed: From	Note: there is a fee for obtaining	medical records for self)	
Dates of information to be disclosed: From to (If left blank, only information from the past two (2) years will be disclosed)  y signing below, you agree to the following:  1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.  2. I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information not covered by federal privacy regulations, this information not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.  3. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of this form.  4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment 5. I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted at the top of this form.  6. I understand that a copy or fax of this document is just as valid as the original document  7. I understand that this authorization will expire one (1) year after signed.  Contact telephone number	3. INFORMATION TO I	BE DISCLOSED:	
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