

LANCASTER RETINA SPECIALISTS, PC
2150 HARRISBURG PIKE, SUITE 370
LANCASTER, PA 17601
PHONE: 717-399-8790 FAX: 717-399-3279

**AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
RECORDS RELEASE**

Date: _____

Patient Name: _____ DOB: _____

Address: _____

I hereby authorize **LANCASTER RETINA SPECIALISTS** to (check one)

_____ Obtain from the following _____ Release to the following

Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that the information being disclosed may include information related to AIDS, HIV, Psychiatric treatment, Drug, Alcohol or substance Abuse.

You must read the following Statements:

1. I understand this Authorization will expire 1 year from signing this form.
2. I understand that I may revoke this Authorization at anytime by notifying Lancaster Retina Specialists
3. You may refuse to sign this Authorization
4. I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I have read and understand this authorization, and authorize use and disclosure of health information about the named patient as described in this authorization.

Signature of Patient or Legal Representative

Date