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COMMUNITY EYE CARE SPECIALISTS

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Authorization for Release of Protected Health Information

I hereby give my permission to release medical information as indicated below:

_____ _____

Patient Name Date of Birth

Records are requested for the purpose of:

☐ Second Opinion ☐ Transfer of Care

☐ Insurance Purposes ☐ Continuing Care

☐ Relocating – (please provide address) _____

_____

☐Other: _____

Indicate specific records to be released:

☐ Office Visits / Testing Dates of Service: _____

☐ Surgery Dates of Service: _____

☐ All Records Dates of Service: _____

☐ Lab Work ☐ Pathology ☐ Imaging

☐ Other: _____

Release Records to: **Release Records from:**

_____ _____

_____ _____

_____ _____

Fax #: _____ _____

E-mail: _____ _____

Phone: _____ _____

I understand that this authorization is effective for a period of one year from the date of signature, unless otherwise specified. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity / person I authorized above to release this information.

_____ _____

Patient Signature Date

_____ _____

Parent (for patients under the age of 18) / Guardian Date

_____

Relationship to Patient

2 Farm Colony Dr
Warren PA 16365
814-726-2303

2A Park Way
Seneca PA 16346
814-677-6404

462 Fairmount Ave
Jamestown NY 14701
716-484-6700

110 E Columbus Ave
Corry PA 16407
814-665-1300

1136 Central Ave
Dunkirk NY 14048
716-366-2033

314 S Franklin St
Titusville PA 16354
814-827-8819

2223 West State St
Olean, NY 14760
716-373-0444