HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

PURSUANT TO 45 CFR 164.508

To: Apple Hill Eye Center

25 Monument Road Suite 297

York PA 17403

Re: Patient Name_____

Date of Birth _____

I authorize the disclosure of protected health information (such as general medical condition, diagnosis, and medications) for the purpose of my continuing medical care to the following family members of other persons:

_____

_____

I understand the following: See CRF 164.508(C)(2)(I-III)

a. I have the right to revoke this authorization in writing at any time, except to the extent that my information has been released in reliance upon this request.
b. My treatment or payment of my treatment cannot be conditioned on the signing of this authorization.

This authorization shall be in force and effect until two years from date of execution at which this authorization expires.

Signature of Patient or Legal Representative Date

Name & Relationship of Legal Representative to Patient

Witness Signature Date