APPLE HILL EYE CENTER
25 Monument Road, Suite 297
York, Pennsylvania 17403-5049
(717) 741-6732 Phone (717) 741-6058 Fax

RECEIVE IN

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____
_____
_____

Fax #: _____

Name of Patient: _____ **DOB**: _____

I authorize you to release my health information to Apple Hill Eye Center.

My next scheduled appointment at Apple Hill Eye Center is on: _____

I request records for date(s) of service from _____ to _____ (records will be provided for all service dates if left blank).
(insert date(s) of service requested)

Please forward my records to address or fax # listed above and send to the attention of:

- ❒ Steven T. Olkowski, M.D.
- ❒ Salman Ali, M.D
- ❒ Michael E. Altman, M.D.
- ❒ Marc J. Hirschbein, M.D.
- ❒ William H. Drusedum, O.D.
- ❒ Matthew J. Link, O.D.
- ❒ Colleen Rae-Jenkins, O.D.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I withdraw this Authorization at any time by writing to the health care provider, but that revoking this Authorization will not affect disclosures made or actions taken before the revocation is received.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.
- I release you from all legal liability that may arise from this Authorization.
- I am entitled to receive a copy of this Authorization.

Printed Name: _____
(Patient or authorized representative)

Signed: _____ Date: _____

Relationship of person authorizing release, if not the patient: _____
You must provide proof our your authority to act on behalf of the patient.