Pediatric Ophthalmology Associates

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (DOB) _____), hereby authorize and request the release of medical information concerning the treatment rendered to me, and to disclose the following protected health information regarding my care. This information is to be released to:

_____

NAME/ NAME OF FACILITY/ CLINIC

_____

PHONE NUMBER

_____

FAX NUMBER

Information is to be used for the following purpose(s):

- ☐ For treatment at this facility
- ☐ For processing of insurance claim
- ☐ Other: _____

****If you prefer to have the medical records printed and mailed you may be subject to a service charge****

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing and addressed to David A. Young, M.D. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from David A. Young, M.D., nor will it affect my eligibility for benefits.

It is the understanding of David A. Young, M.D. and the staff that the information being released is privileged and confidential and will not be used for anything other than the intent of this request.

_____	_____	_____
PATIENT SIGNATURE (if over 18 y/o)	**PATIENT NAME**	**DATE**
_____	_____	_____
PARENT'S NAME/LEGAL GUARDIAN NAME	**PARENT'S NAME/LEGAL GUARDIAN NAME**	**DATE**