Batchelet Eye, LLC

1743 S Center St Ext. Grove City, Pa 16127

Phone:724-766-0986 Fax: 724-558-9960

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I hereby authorize Batchelet Eye to ☐ RELEASE MY RECORDS TO OR

☐ REQUEST MY RECORDS FROM

Name of Facility/ Person _____

Address _____

Phone _____ Fax _____

Reason for release: Continued Care Other _____

Dates of Treatment Requested: Last 2 years visits including testing

I authorize the above-named source to release or disclose the following information. Any medical records or other information regarding my treatment, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or testing for HIV.

I authorize the use of fax for the release or disclosure of the information described above. A photocopy of this consent will have the same effect as the original. This authorization to release patient information will expire 90 days after it is signed, unless revoked by written request. Two signatures required for verbal consent only.

Signed: _____ Date: _____

Signed: _____ Date: _____

If not patient, please check appropriate space

Parent _____ Guardian _____ Power of Attorney _____ Witness _____