Peter S. Schwartz, MD ~ Pediatric & Adult Ophthalmology
2333 North Triphammer Road, Suite 403, Ithaca, NY 14850 ~ Tel.: (607) 266-7600 ~ Fax: (607) 266-7601

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Our office is dedicated to maintaining the privacy of your **P**rotected **H**ealth **I**nformation. This includes such data as your name, address, phone number, date of birth, Social Security number, account information, medical record number, or any other unique identifying number. In conducting our business, we will maintain records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

I hereby authorize the use or disclosure of my Protected Health Information as described below. I understand that this authorization is voluntary. I also understand the disclosed information may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Patient Name: _____ Date of Birth: ____/____/____ SSN: _____

I authorize Dr. Peter S. Schwartz to *RELEASE* copies of my records *TO:*

_____
Name of Physician or Institution, etc.

_____
Address (please FULLY complete!)

_____
City, State, ZIP Phone/Fax Number

_____
Dates of treatment for which you need records

I authorize Dr. Peter S. Schwartz to *OBTAIN* copies of my records *FROM:*

_____
Name of Physician or Institution, etc.

_____
Address (please FULLY complete!)

_____
City, State, ZIP Phone/Fax Number

_____
Dates of treatment for which you need records

*****PLEASE CHECK ALL THAT APPLY:**

Information to be RELEASED:

____ Office notes
____ HRT's
____ A Scans
____ B Scans
____ Visual Field
____ Fundus Photos
____ Corneal Topography
____ Other

PLEASE SEND REQUESTED RECORDS TO:

ATTENTION: MEDICAL RECORDS
Peter S. Schwartz, MD, Ophthalmology
2333 North Triphammer Road, Suite 403
Ithaca, NY 14850
Tel.: (607) 266-7600 Fax: (607) 266-7601

Information will be used / disclosed for the following purpose(s):

____ Continuation of Care (for another Provider) ____ Pending Appointment Date:_____
____ Personal Use ____ Other:_____

The patient or the patient's representative MUST read and initial the following statements:

____ 1. I understand that my health care will not be affected if I do not sign this form.
____ 2. I understand that I may revoke this authorization at any time, in writing, by notifying our office at: Peter S. Schwartz, MD, 2333 N. Triphammer Road, Suite 403, Ithaca, NY 14850. Phone: (607) 266-7600. If I do revoke the authorization, it will not have any effect on any actions taken by Dr. Peter Schwartz prior to his receipt of the Revocation.
____ 3. Unless otherwise noted, I understand this authorization **WILL EXPIRE** when ALL REQUESTED RECORDS have been transferred OR when a period of NINETY DAYS has transpired.
____ 4. I understand that routine requests typically take 7-10 days to process.
____ 5. I understand that there **may be a charge of 0.75¢ per page** due upon receipt of my medical records.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to Patient

Approved: _____ Date: _____