

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Our office is dedicated to maintaining the privacy of your Protected Health Information. 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:**

- |                                       |                                             |
|---------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Office notes | <input type="checkbox"/> Visual Field       |
| <input type="checkbox"/> HRT's        | <input type="checkbox"/> Fundus Photos      |
| <input type="checkbox"/> A Scans      | <input type="checkbox"/> Corneal Topography |
| <input type="checkbox"/> B Scans      | <input type="checkbox"/> 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):**

- |                                                                      |                                                          |
|----------------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Continuation of Care (for another Provider) | <input type="checkbox"/> Pending Appointment Date: _____ |
| <input type="checkbox"/> Personal Use                                | <input type="checkbox"/> 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