NEW YORK MEDICAL & SURGICAL
EYE CARE

110 East 40th St., Suite 404
New York, NY 10016
Telephone: (212) 242-2200
Fax: (212) 242-3003
Email: info@nyeyecare.com

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

Patient Name: _____
First Name Middle Name Last Name

Date of Birth: _____

Social Security Number: _____

Patient Address: _____
Street City State Zip Code

Patient Cell Number:_____

I hereby authorize and request you to release the complete history records in your possession, concerning my illness and/or treatment during the period from _____ to _____

Kindly forward these records to:

Name:_____

Address:_____
Street City State Zip Code

Phone:_____Fax:_____

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

1. I understand that my health care and payment for my health care will not be affected if I do not sign this form. INITIALS: _____
2. I understand that I may see and copy the information described on this form if I ask for it, and that New York Medical & Surgical Eye Care will give me a copy of this form after I sign it. INITIALS: _____
3. I understand this authorization WILL EXPIRE when ALL REQUESTED RECORDS have been transferred OR when a period of NINETY DAYS has elapsed. INITIALS: _____
4. I understand that I may revoke this authorization at any time by notifying in writing at our office at New York Medical & Surgical Eye Care, 110 East 40th Street, Suite 404, New York 10016, but if I do revoke it, the revocation will not have an effect on any actions New York Medical & Surgical Eye Care took before it received the revocation. INITIALS: _____
5. I understand that routine requests typically take 10-14 business days to process. I understand that there is a charge of 0.75¢per page due upon request of my medical records. INITIALS: _____

Purpose: ☐Transfer of Care ☐Insurance Eligibility Benefits ☐Personal

☐ Specialist/Second Opinion

Delivery options: ☐Pick up at our office ☐Mail to patient's address listed on page 1

☐Fax: _____

☐Email: _____

Signature of patient or patient's representative (state relationship if representative)

Patient Name/Patient's Representative: _____

Patient Signature/Patient's Representative: _____

Relationship to Patient: _____

Date: _____