AUTHORIZATION

PEDIATRIC OPHTHALMOLOGY ASSOCIATES, INC.
555 S. 18TH ST. 4-C
Columbus, Ohio 43205
P: 614-224-6222 | F: 614-241-5232

Authorization to Release Protected Health Information to Pediatric Ophthalmology Associates, Inc.

I hereby authorize (organization/facility/person)_____

at (address) _____Fax #: _____

_____ _____
PATIENT'S NAME **DATE OF BIRTH**

Please send the medical records to Pediatric Ophthalmology Associates, Inc via the following method:
Mail: Pediatric Ophthalmology Associates, Inc. 555 S. 18th Street, Suite 4-C, Columbus, OH 45205
OR
Fax: ATTN: Lisa G. Fax Number: 614-241-5232

Description of Records to be Released/Disclosed:

_____

Specify Dates:

_____

The purpose of the authorized use or disclosure described above is as follows:

___ Transfer of Records to New Treatment Provider
___ Insurance Review or Dispute
___ Attorney Review
___ School Review
___ Personal Use
___ Other (be specific) _____

Other Information:

1. As described in the Notice of Privacy Practices of Pediatric Ophthalmology Associates, Inc., I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Pediatric Ophthalmology Associates, Inc. in reliance on this authorization, by sending a written revocation to Pediatric Ophthalmology Associates, Inc 555 S. 18th St 4-C Columbus, OH 43205 ATTN: Privacy Officer.
2. In understand that I am not required to sign this authorization form and that Pediatric Ophthalmology Associates, Inc. will not condition the provision of treatment t or payment to me on the signing of this form.
3. I understand that in this authorization includes the use and/or disclosure of information from the patient medical or financial records as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AID related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).
4. I understand that if the person or entity that receives the above information is not a health care provider covered by federal privacy regulations, the information described may be redisclosed by such person or entity and will likely no longer be protected by federal privacy regulations.

This authorization will automatically expire 60 days if no expiration option is indicated below:
*** Insert applicable date or specific event _____**

_____
Signature of Patient/Parent/Legal Representative **Date**

_____
Address

Dr. # _____ Dr. Fx # _____