South Hills Eye Associates, Ltd.
Authorization for Release of Protected Health Information

I hereby authorize South Hills Eye Associates, Ltd. To release information from the record of

_____/_____/_____
Patient Name Birth Date Social Security Number

_____

To:_____

_____

The records to be released should include physician office/clinic records and /or a report of my diagnosis, treatment, prognosis and recommendations as well as other data pertinent to my treatment, including visual fields, photos, and any other diagnostic test results.
Date: From_____ to_____ or ALL HIV, Behavioral Health and Drug and Alcohol information contained in the parts of the record (s) indicated above will be released through this authorization unless otherwise indicated.

I understand the following:

- That my health record (s) will not be released or obtained by South Hills Eye Associates, Ltd., unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization), unless permitted by HIPAA regulations for Care and Treatment, Payment, or Health Care Operations .
- That health record (s) released by South Hills Eye Associates, Ltd., may possibly be re-disclosed by the facility/person that receives the record (s) and therefore (1) South Hills Eye Associates, Ltd., and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- That this Authorization is in effect for a period of 90 days from the date of signature , unless a specific timeframe is documented; however, no time frame specified shall go beyond one year from the date of signature
- That I have the right to revoke this Authorization form at any time by sending a written request to Records Custodian, South Hills Eye Associates, Ltd., at the following address: 713 Washington Road, Pittsburgh, PA 15228.
- That my decision to revoke the Authorization does not apply to any release of my health record (s) that may have taken place prior to the date of my request to revoke the Authorization.
- That my decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and that I may be liable for payment of the claim.
- That I am entitled to a copy of this completed Authorization form.

GENERAL AUTHORIZATION

_____ _____
Patient Signature Date

The above named patient is unable to provide a signature due to:_____

_____ _____
Legal Representative Signature Date

_____ _____
Witness Date

Copy provided to patient