Pocono Eye Associates, Inc.

100 Community Drive, Suite 204A
Tobyhanna, PA 18466
Phone: 570.895.4550
Fax: 570.895.4461

300 Plaza Court, Suite A
East Stroudsburg, PA 18301
Phone: 570.421.8842
Fax: 570.476.5842

1650 Route 209
Brodheadsville, PA 18322
Phone: 570.992.4000
Fax: 570.992.4099

This form provides authorization for the use or disclosure of your protected health information as required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164. Please complete as indicated below, and sign and date at the bottom.

1. AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION:

I authorize Pocono Eye Associates to release protected health information for _____ to:
Print Patient Name

_____ _____
Name of Individual or Facility Address or Fax Number

2. EFFECTIVE PERIOD:

This authorization for release of information covers the period of healthcare: (circle one)

a. from _____ to _____ , **OR**

b. all past, present, and future periods.

3. EXTENT OF AUTHORIZATION: (circle one)

a. I authorize the release of my complete health record, OR

b. I authorize the release of my complete health record with the exception of the following information:

☐ Please specify: _____
Note: some information cannot be separated from exam notes

4. PURPOSE:

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. EXPIRATION:

This authorization shall be in force and effect until expressly revoked as set forth below, at which time this authorization expires.

6. REVOCATION:

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

7. PROTECTION:

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____ _____
Patient/Personal Representative Signature Patient Date of Birth Date

_____
Print Name of Personal Representative (if applicable)

_____
Relationship to Patient (if applicable)