5275 East Trindle Road
Mechanicsburg, PA 17050
Ph: 717-697-7288
Fax: 717-697-6010

Authorization for DISCLOSURE of PATIENT HEALTH CARE INFORMATION

Name ____
LAST, FIRST MIDDLE INITIAL PHONE NUMBER

Date of Birth __________________ Former Name/Alias (if any) __________________
MM/DD/YYYY LAST, FIRST MIDDLE INITIAL

I authorize the release of my records from:

☐ Boshinski Eye Clinic

☐ Name ____

Address ____

City ____________________ State ____________________ Zipcode ____________________

Phone ____________________ Fax ____________________

I authorize the release of my records from the above entity to:

☐ Boshinski Eye Clinic

☐ Name ____

Address ____

City ____________________ State ____________________ Zipcode ____________________

Phone ____________________ Fax ____________________

I specify the following information to be released:

☐ entire record ☐ only those portions pertaining to: ____________________

I authorize release of my records as specified above. I hereby release Boshinski Eye Clinic and their staff from all legal responsibility and liability that may arise from the release of information authorized by this document. I understand that I will be charged $1 per page of records that are released.

This authorization is valid for one time access and expires thirty (30) days from the date of signature.

Authorized Signature: ____ Date: ____________

Name if signed by other than patient: ________________________________ Relationship: ____________

Signature of Witness: ____

Please allow 14 business days for any records to be sent or processed.