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# CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION (PHI)

| Patient's Name: | | Date of Birth: | |
|---|---|---|---|
| Maiden Name: **(if applicable)** | | Phone # | |

**I request and authorize the release of my health information and disclosure of protected health information:**

**To / From :**

Office:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: **(**____**)**_____

Fax: **(**____**)**_____

**To / From :**

**CNY Eye Care**
**5700 West Genesee Street**
**Suite 105**
**Camillus, NY 13031**
**Phone (315) 487-3937**
**Fax (315) 488-3563**

**REASON FOR RELEASE OF PHI:**

- ☐ **Continuation of medical care**
- ☐ **Transfer of medical care. Reason for transfer: _____Date effective: _____**
- ☐ **Other _____**

**THIS REQUEST APPLIES TO:**

- ☐ All Eye exam records, eyeglass and/or contact lens records and pertinent tests
- ☐ Other**:** _____

**I understand that I have the right to revoke this authorization at anytime. Request to revoke an authorization must be directed in writing to CNY Eyecare. I understand that exceptions to the right to revoke are: (1) where the provider has acted in reliance upon the authorization; (2) if the authorization was obtained as a condition of obtaining insurance coverage and law provides the insurer with the right to contest a claim under the policy (3) as otherwise required by law.**

**I understand that in the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by the privacy regulations. I also understand that this authorization will expire in ONE YEAR. I further understand that this authorization is voluntary and CNY Eyecare will not refuse treatment based on my refusal to sign. I hereby authorize release of the requested medical information.**

| Patient Signature: | | Date Signed: | |
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