Robert Weisenthal, M.D.
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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
P.O. Box 48
DeWitt, NY 13214
Phone (315) 445-1577
Fax (315) 445-4862

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:	