CHESTER COUNTY EYE CARE ASSOCIATES
Commons at Oaklands
740 West Lincoln Highway
Exton, PA 19341
Phone: 610-696-1230
Fax: 484-723-2088

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE AND REQUEST THE RELEASE OF MY RECORDS AND/OR EXCHANGE OF INFORMATION REGARDING SERVICES RECEIVED FROM:

PROVIDER OF INFORMATION		RECIPIENT OF INFORMATION
_____		Chester County Eye Care Associates
_____	TO	Commons at Oaklands
_____		740 West Lincoln Highway
_____		Exton, PA 19341

I ADDITIONALLY AUTHORIZE AND REQUEST THE RELEASE OF MY RECORDS AND/OR EXCHANGE OF INFORMATION REGARDING SERVICES RECEIVED FROM:

PROVIDER OF INFORMATION		RECIPIENT OF INFORMATION
Chester County Eye Care Associates		_____
Commons at Oaklands	TO	_____
740 West Lincoln Highway		_____
Exton, PA 19341		_____

PRINT NAME OF PATIENT _____ **DATE OF BIRTH** ____/____/____

REASON FOR RELEASE: ____ **Consult (1-2 years)** ____ **Patient Move / Change of Physician (full chart)**
____ **Other (list required information below)**

THE SPECIFIC INFORMATION TO BE DISCLOSED IS:

___ Out-patient and in-patient records
___ Presence in treatment/attendance
___ Assessment, history, diagnosis, recommendations
___ Psychiatric/Psychological/Psychosocial history and evaluation
___ Other, specify_____
___ Medical and psychiatric records
___ Progress in treatment/progress notes
___ Discharge summary and plans
___ HIV/AIDS records

This consent is subject to written revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate in twelve (12) months from date of client signature below.
I have carefully read and understand the above statements. I voluntarily consent to disclosure of the above information about, or records of my condition to the person(s) or agency(s) named above. I understand that my records are protected under Federal Law 42 U.S.C. 290 dd-2, Federal Regulation 42CFR Part 2, PA State Law 71P.S. 1690.108 (Act 63) and PA State Regulation 28 PA, Code Subsection 709.28 and 4 PA, Code Subsection 255.5 governing the Confidentiality of Alcohol and Drug Abuse Patient Records, and my records are protected by the Confidentiality of HIV Related Information Act 148.

_____/_____ _____/_____ _____
Signature of Patient or Responsible Person Date Signature of Witness Date Physician Approval

_____ **Verbal Response given** (Patient physically unable to give written consent.)
A verbal consent requires two (2) witness signatures. I witness that the patient (or responsible person) is definitely unable to provide a signature at this time, but understands the nature of the release and freely gives his/her consent.

_____/_____ _____/_____
Witness Date Witness Date

Rev. 7/2008

Records Received_____