Campus Eye Center

www.campuseyectr.com
2108 Harrisburg Pike, Suite 100
Lancaster, PA 17601
Phone: 717-974-9661
Fax: 717-974-9669

222 Willow Lakes Drive
Willow Street, PA 17584
Phone: 717-464-4333
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AUTHORIZATION FOR USE OR RELEASE OF MEDICAL RECORDS

1. PATIENT INFORMATION:

Name: _____ **DOB:** _____ **Phone#**:_____

Address: _____**City/State:** _____**Zip:**_____

2. AUTHORIZES:

Campus Eye Center
2108 Harrisburg Pike, Suite 100
Lancaster, PA 17604-Fax: 717-974-9669

SEND MY INFORMATION TO:

Name: _____

Address: _____

Fax #: _____

(Note: there is a fee for obtaining medical records for self)

RECEIVE MY INFORMATION FROM:

Name: _____

Address:_____

Fax #: _____

3. INFORMATION TO BE DISCLOSED:

☐ Entire medical record

☐ Specific records/information as follows: _____

Dates of information to be disclosed: From _____ to _____
(If left blank, only information from the past two (2) years will be disclosed)

By signing below, you agree to the following:

1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
2. I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of this form.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5. I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted at the top of this form.
6. I understand that a copy or fax of this document is just as valid as the original document
7. I understand that this authorization will expire one (1) year after signed.

_____ _____ _____
Signature of Patient or Authorized Person | Date | Contact telephone number

_____ _____
Relationship of Authorized person | Reason Patient is unable to sign authorization

OFFICE USE ONLY: Acct #: _____ Release date: _____ Initials:_____