("Record Release Form")

Authorization For Use Or Disclosure Of Protected Health Information

Robert A. Schumer, M.D., Ph.D./Hudson Valley Glaucoma Care

1. Patient Name: _____.

2. Social Security Number: _____-_____-_____ Date of Birth: _____.

3. I hereby request and authorize_____
(hereafter referred to as **THE REQUESTED PRACTICE**), its physician(s) and/or administrative, clerical and clinical staff to disclose the following protected health information to:

Robert A. Schumer, M.D., Ph.D.
Hudson Valley Glaucoma Care
150 Aaron Court
Kingston, NY 12401

Phone: (845) 331-6670
Fax: (845) 331-6672
Email: office@hvglaucoma.com

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(Specifically and meaningfully describe the protected health information to be used or disclosed such as date of service, type of service, origin of information, etc. If date of service not specified, then all date(s) of service are requested; if no specific category of health information is named, then all records are being authorized and requested.)
CHECK ALL THAT APPLY:

X Office Notes for Date(s) of Service:

X Other (Describe): **VISUAL FIELDS**

This protected health information is being used or disclosed for the following purposes:

[**X**] At the request of the named individual (if the request is made by the patient and the patient does not wish to state a specific purpose.)

[ ] Other (specify):

4. This authorization shall be in force and effect until:

Date of Expiration*:* _____.
(MM/DD/YY) (**one year from date of signing**)

at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification, signed by me, or on my behalf by my authorized personal representative, to **THE REQUESTED PRACTICE**'s Privacy Officer.

I understand that a revocation is not effective to the extent that **THE REQUESTED PRACTICE's** physician(s) and/or administrative, clerical and clinical staff has taken action in reliance on the authorization for the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I further understand that a revocation is not effective until it is received by the **THE REQUESTED PRACTICE**'s Privacy Officer.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law under the Privacy Rule.

I understand that compliance with this authorization is voluntary. **THE REQUESTED PRACTICE** shall not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I release **THE REQUESTED PRACTICE**, its physician(s) and/or administrative, clerical and clinical staff from legal responsibility or liability for the disclosure of the records as authorized on this form.

5. _____. _____

Signature of Patient or Personal Representative DATE

(Form MUST be completed before signing.)

6. _____.

Print Name of Patient or Personal Representative

_____.

Description of Personal Representative's Authority

A copy of this document must be given to the patient or legally authorized representative upon request

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REVOCATION

I hereby revoke the authority given above. I understand that this revocation is subject to the terms and conditions above.

_____. _____

Signature of Patient or Personal Representative DATE

(Form MUST be completed before signing.)

_____.

Print Name of Patient or Personal Representative

_____.

Description of Personal Representative's Authority