

Adam R. Thode, M.D.
Bethany M. Rommel, M.D.
Thomas H. Tien, M.D.



2115 Noll Drive
Lancaster, PA 17603
Telephone (717) 393-7980
Fax (717) 509-5079
MRTEyes.com

Authorization To Receive/Release Health Information

Patient Name _____ Date of Birth _____

Address _____ City/State/Zip _____

I hereby authorize the disclosure of my health Information FROM:

The following information from my medical record, Physician Office Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, All other Diagnostic Studies, Psychiatric and Psychological Evaluations, Therapy Notes, Mental Health Progress notes, etc.

Name of Person/Organization Releasing Information

Address City/State/Zip

Phone Number/Fax Number

To release my Information TO:

Name of Person/Organization Receiving Information

Address City/State/Zip

Phone Number/Fax Number

Information to be released:

___ Medical Records from last 3 years from date of signature

___ Other (please list) _____

This authorization remains in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X _____
Printed Name of Patient or Personal Representative

X _____
Signature of Patient or Personal Representative DATE

Description of Personal Representative's Authority (attach necessary documentation)

.....
Date Sent: _____ By: _____ Via: _____