Strasburg Family Eyecare, LLC
Dr. Rob Lauver, III and Dr. Maia Moyer
20 Lancaster Ave
Strasburg, PA 17579
717-687-8141 * 717-388-4817 Fax

MEDICAL RECORDS REQUEST

Patient: _____ DOB: _____ Date: _____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

By signing this authorization, I authorize Dr. Lauver, III to get, use, and/or disclose certain protected health information (PHI) about me:

( ) RELEASE HEALTH INFORMATION TO:

Strasburg Family Eyecare, LLS

Fax: 717-388-4817

20 Lancaster Ave., Strasburg, PA 17579

PHONE: 717-687-8141

( ) OBTAIN HEALTH INFORMATION FROM:

NAME: _____

ADDRESS: _____

_____

PHONE/FAX: _____

This authorization permits Dr. Lauver, III &/or Dr. Maia Moyer to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used and disclosed, such as date(s) of services, type of services, level of detail to be released, etc.)

( ) All Health information

( ) Only these items: _____

_____

( ) The information will be used or disclosed for the following purpose: _____

I do not have to sign this authorization in order to received treatment from Dr Lauver, III. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed, pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization, in writing, except to the extent that the proactive has acted in reliance upon this authorization. My written revocation must be submitted to Dr. Lauver, III's office at 204 W. Hillcrest Ave, Strasburg, PA, 17579.

SIGNATURE of ( ) Patient ( ) Legal Guardian (relationship to patient: _____)

X_____ Date: _____

Printed Name of Signer: _____

Location: Dropbox;SfeDocuments;MedicalRecordsRequest.doc