Sightline Laser Eye Center & Ophthalmic Associates
2100 Corporate Drive, Suite 400, Wexford, PA 15090
phone 724-933-5588 • fax 724-933-6051

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

TO: _____

_____

_____

_____

RE: _____ DOB:_____

ADDRESS: _____

PHONE: _____

I request that all my records including physician office records/clinical notes, and/or reports of my diagnosis, treatment, prognosis, and recommendations as well as any other data including visual fields, nerve fiber testing, pachymetry, and contact lens information be sent to the address below.

I understand that HIV, Behavioral Health and Drug and Alcohol information contained in parts of the record will also be released unless otherwise indicated.

I understand that I have the right to revoke this authorization at any time by sending a written request to the above address.

_____ _____

Patient Signature (or Legal Representative) Date

PLEASE FAX TO (724) 933-6051 OR MAIL TO:

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Wexford, Pa 15090