1005 Beaver Grade Road, Suite G10
Moon Township, PA 15108
Phone: 412-308-9111 / Fax: 412-308-9112
Email Records to records@focusoneyecare.com

Authorization for Release of Medical Information

Patient's Name:_____ Date of Birth:_____
Address:_____
Date of Request:_____ Date Needed: _____

OR

☐ I authorize Focus on Eyecare **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

☑ I authorize Focus on Eyecare to **obtain information from:**

Pediatric Ophthalmology and Strabismus
Name of Provider or Facility

125 Graham Park Drive, Suite 300
Address

Cranberry Township, PA 15108
City, State, Zip Code

724-772-3388 / 724-772-7021
Phone # / Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one)
☐ Insurance Coverage ☑ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one)
☑ Entire copy of medical record including last medical and vision insurance information on file.
☐ Specific Information: (Select one or more, as applicable)
☐ Last Examination ☐ Photos ☐ Lab Results ☐ Other
☐ Last examination including last medical and vision insurance information on file.

AUTHORIZATION VALID FOR: (Check one)
☑ One year from the date of this authorization OR _____ (insert date). This authorization applies to the records of treatment received on or prior to the date of this authorization.

***I understand that*:**

- My right to healthcare treatment is not conditioned under this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.

NOTE: Medical records are faxed to 412-308-9112 or emailed to records@focusoneyecare.com.

Signature of Patient or Representative:_____ Date:_____
Relationship to Patient: (*if requester is not the patient*) _____

Office use only:
MR#:_____ Date: _____ Staff Member Sending:_____