ARLEO EYE ASSOCIATES
100 Uptown Road
Ithaca, NY 14850
ph 607-257-5599 fax 607-257-3972

232 W. Genesee Street, Suite 2
Auburn, NY 13021
Ph: 315-252-9571
Fax: 315-702-8371

42 N. Franklin Street
Watkins Glen, NY 13081
Ph: 607-210-4042
fax: 607-210*4271

AUTHORIZATION TO RELEASE INFORMATION

_____ _____
Patient Name **Date of birth**

Please list anyone that may contact us on your behalf:

_____ _____
Full Name (please print) **relationship**

_____ _____
Full Name (please print) **relationship**

_____ _____
Full Name (please print) **relationship**

Please check all that apply:

Medical records _____ Billing _____ Prescriptions _____ other_____ (please explain)

Expiration date of authorization:
This authorization is effective through ____/____/____ (not to exceed 1 year) unless revoked or terminated earlier by the patient or their representative.

_____ _____
Patient or guardian/POA Signature **date**

_____ _____
Witness **date**

Right to terminate or revoke authorization:
You may revoke or terminate this authorization by submitting a written revocation to Arleo Eye Associates.

Rights of the individual:

You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.