

Manchester Ophthalmology, LLC

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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed

The information covered by this authorization includes:

- Release of all health information
- Release of all health information **excluding**
 - HIV Testing and Results
 - Alcohol or Drug Abuse Records
 - Psychiatric Records
- Release only specified health information as follows:

Person(s) Authorized to Disclose Information

Information above will be disclosed by:

Name and Address of Person or Organization Information is Being Requested From

Person(s) to Whom Information May be Disclosed

Information described above may be disclosed to:

Name and Address of Person or Organization Information to be Disclosed To

Patient Name: _____ **D.O.B.** _____
Please Print

Signature: _____ **Date:** _____

*There may be a charge of \$.45 per page for copying records

For Office Use Only:
Date Copied: _____
Copied By: _____

Patient Account _____
Date Mailed/Picked up: _____