REQUEST FOR MEDICAL RECORDS

Authorization for Use of Disclosure of Information for purposes requested by the physicians at Pajka Eye Center and the Eye Surgery Center of Western Ohio.

I, ______________________________, hereby authorize:

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To disclose my protected health information to:

Pajka Eye Center and
Eye Surgery Center of Western Ohio
855 W. Market St., Lima, Ohio 45805

This protected health information is being used or disclosed for the following purposes:

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This authorization shall be in effect for 1 year from the date this document was signed at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Administrator at **Pajka Eye Center and the Eye Surgery Center of Western Ohio, 855 W. Market St. Lima, Ohio 45805**. I understand that a revocation is not effective to the extent that this office has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

____________________	____________________________	__________
Name of Patient	Signature of Patient or Personal Representative	Date