



ALBANY-TROY CATARACT & LASER ASSOCIATES

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Patient Authorization for Practice to Release Protected Health Information (PHI) to 3rd Party

I authorize Albany-Troy Cataract and Laser Associates to disclose my PHI
to the following party or parties _____.

This authorization will expire on _____ (or never if left

blank). When my information is used/disclosed pursuant to this

authorization, it will no longer be protected by the federal HIPPA Privacy

Rule. I may revoke this authorization by submitting a written letter to the

Privacy Officer at Albany-Troy Cataract and Laser Associates, 2222 Sixth

Avenue, Troy, NY 12180.

Signed by: _____

Patient's Name: _____

Relationship to Patient: _____