EMIL W. CHYNN, MD, FACS, MBA – Park Avenue LASEK
102 E. 25th St. (& Park Avenue South), NY, NY 10010
(212) 741-8628 info@ParkAvenueLASEK.com

Request for Patient's Health Records—TO US

Patient Name: **Date of Birth:**

By signing this, I authorize all parties below to use, release, or disclose the protected health information described:

Doctor from whom info. is requested:	**If patient wants records complete this part with your contact info:**	**Doctor to whom info should be sent:**
Name:		Emil William Chynn, MD, FACS, MBA
Address:	Email:	102 E. 25th St, NY, NY 10010
		We Prefer PDF if at all possible! ☺
Phone:		**info@ParkAvenueLASEK.com**
Fax:		fax (**not** preferred): 212-741-2390

Expiration date: one year after date at bottom of this form

"I authorize all relevant medical records, particularly my ophthalmologic medical records, including any relevant eye tests, particularly within the year prior to the date of signing below; to be sent to Dr. Chynn's email address and myself if indicated above. I understand that the information disclosed may include a history of AIDS; sexually transmitted diseases (STD); human immunodeficiency virus (HIV) infection; behavioral health services or psychiatric care; treatment for alcohol or drug abuse, or similar conditions. I understand that there may be information in these records that I would not wish to be released. I have been given the opportunity to review Park Avenue LASEK (PAL) HIPAA Practices, which are standard in medicine in the US, and available on millions of websites. I understand that I may discuss any concerns I may have about the use/misuse of my health information with PAL. I understand that PAL assumes no responsibility for the use/misuse by others of my health information disclosed under this authorization. I release PAL, its agents and employees from all legal liability that may arise from this authorization. I do not have to sign this authorization in order to receive treatment from PAL and have the right to refuse to sign this authorization. However, I understand that if I do not release my entire eye history to Dr. Chynn and PAL, that may adversely affect my care/treatment/results, for which I would then be at least partially at fault, for withholding relevant information that might have affected my care/treatment/results. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I have the right to revoke this authorization in writing except to the extent that PAL has acted in reliance upon this authorization."

Name of Patient **Signature of Patient** **Date**