



John A. Hoepner, M.D.
Glaucoma, Cataract Surgery, Retinal Electrophysiology

Evis Petrela, M.D.
Comprehensive Ophthalmology, Cataract Surgery, Glaucoma

David B. Torrales, O.D.
Doctor of Optometry

September 29, 2025

Dear Syracuse Eye Center Patients:

Please be advised that after more than four decades of serving our patients, **Syracuse Eye Center will be closing on November 30, 2025**. Medical/Surgical Services and Routine Eye Care/Eye Exams will no longer be provided.

Ocutique, the optical shop, will remain open at 612 University Avenue in Syracuse and will continue to dispense eyewear and contact lenses to those with valid NYS glasses or contact lens prescriptions.

Please note, all previously scheduled appointments with Dr. Petrela and Dr. Torrales after the date of closure (November 30, 2025) have been cancelled, and no medication prescriptions will be renewed.

Due to the closure of Syracuse Eye Center, we urge you to place yourself under the care of another provider as quickly as possible. If you are under Dr. Petrela's care, you may contact her Camillus office to schedule an appointment (315-671-9035), or you can arrange to place yourself under the care of another provider.

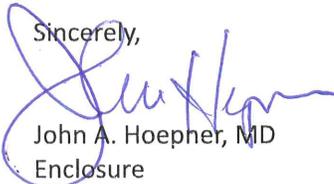
Your medical records are confidential and will be securely maintained in accordance with the law. A copy of, or a part of your records can be transferred to another provider or released directly to you or to a person you designate with your permission. Please complete and sign the enclosed medical records release form and return it by mail to Syracuse Eye Center as quickly as possible so we may provide you or your new doctor with a copy of your medical records.

Please Note:

- Copies of medical records transferred directly to another provider or picked up in person from Syracuse Eye Center will be free of charge until January 30, 2026.
- You may be charged for the copying and transmittal of the records in accordance with applicable state law for records requested to be mailed.
- After January 31, 2026, your medical records will be securely transferred to a records management company where they will continue to be maintained in accordance with applicable confidentiality and security standards and with other applicable laws. You will receive another notification by mail informing you of the upcoming medical records transfer and how to access your medical records from February 1, 2026, and beyond.

We at Syracuse Eye Center have all valued our relationship greatly. Thank you for your loyalty and friendship over the years. It has been a great pleasure and privilege providing for your eye care needs.

Sincerely,



John A. Hoepner, MD
Enclosure

612 University Avenue, Syracuse, NY 13210
Tel 315.422.2020 • Fax 315.422.7339

www.syrelectr.com

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

SYRACUSE EYE CENTER	
Name of Person/Organization Releasing Information	
612 UNIVERSITY AVENUE	SYRACUSE, NY, 13210
Address	City / State / Zip
(315) 422-2020	(315) 422-7339
Phone Number	Fax Number

To Release my Information To:

Name of Person/Organization Receiving Information	
Address	City / State / Zip
Phone Number	Fax Number

INFORMATION TO BE RELEASED:

Complete Medical Record
 Medical Records for Specific Dates of Service (please list) from _____ to _____
 Other (please list) _____

This authorization remains in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X _____ X _____
PRINTED Name of Patient or Personal Representative **SIGNATURE** of Patient or Personal Representative **DATE**

Description of Personal Representative's Authority (attach necessary documentation)



Date Sent: _____ **By:** _____ **Via:** _____