TRI-CENTURY EYE CARE

Medical Records Request Authorization

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

HOME PHONE: _____ ALT. PHONE: _____

DATE OF REQUEST: _____

RECORDS REQUESTED FROM (Doctor's name) _____

I authorize a one-time disclosure of the information listed below to Tri-Century Eye Care, PC. I understand that when this release of information is made to Tri-Century Eye Care, PC, the original party is no longer responsible for the privacy of the released information and Tri-Century Eye Care, PC will protect the privacy of the information in accordance with its Notice of Privacy Practices.

What medical information do you want released (check all that apply)?

- ☐ Entire medical record
- ☐ Specific date of service or range: _____ (to _____)
- ☐ A specific condition _____
- ☐ Lab or Test Results (e.g. visual field, OCT) _____
- ☐ Financial statement _____
- ☐ Other _____

Purpose of disclosure: _____

Release to:

Tri-Century Eye Care, PC
319 2nd Street Pike
Southampton, PA 18966

Patient (or legal representative) signature: _____

Date: _____