



**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:** \_\_\_\_\_

**Southampton**  
319 Second Street Pike  
Southampton, PA 18966  
P: 215.355.4428  
F: 215.355.0790

**Bristol**  
216 Mill Street  
Bristol, PA 19007  
P: 215.781.2020  
F: 215.785.1230

**Langhorne**  
1 Cornerstone Dr, Ste 200  
Langhorne, PA 19047  
P: 215.752.8888  
F: 215.752.8915

**New Britain**  
352 E Butler Avenue  
New Britain, PA 18901  
P: 215.355.4428  
F: 215.230.9994