TRI·COUNTY EYE
Physicians & Surgeons

www.tricountyeye.com

Medical Records Release Authorization

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

HOME PHONE: _____ ALT. PHONE: _____

DATE OF REQUEST: _____

I authorize a one-time disclosure of the information listed below to the recipient listed below. I understand that when this release of information is made to the below recipient, Tri-County Eye Physicians & Surgeons, PC is no longer responsible for the privacy of the released information.

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: _____

List the complete name and address of the recipient of this information.

Recipient _____ *Practice Name* _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Patient (or representative) signature: _____ **Date:** _____

Moving? Please provide your new address and phone number:

Address _____

City, State, Zip _____ *Phone* _____

319 Second Street Pike
Southampton, PA 18966
Tel 215.355.4428
Fax 215.355.0790

352 E. Butler Avenue (Rt. 202)
New Britain, PA 18901
Tel 215.230.4700
Fax 215.230.9994