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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/HEALTH INFORMATION

Please complete this form in its entirety. This release is not valid if it does not contain the patient's original signature, or legally authorized individual's signature, and date signed.

	e the provider listed be	elow (Name and Address) to re	erease my record	
To disclose inform	nation from the medica	al/health records of patient:		
Name:	First			
Last	First	MI	(Prev	ious name)
Birthdate:	SS#:	Telephone:	Telephone:	
Address:		City		
Stre	eet	City	State	Zip
This information	is to be released to pro	vider listed below (Name and	Address):	
☐ Second opinion☐ Ins. Change	authorization (Check and Moving □ Club □ To have copy for selectors of healthcase)	hanging physicians ☐ Con	tinued coordinate	
From (date	e):	To (date):		
*****	******	********	******	******
include treatment for abortion, and/or HIV consent is valid for address, provided sat able to revoke this a	physical and mental illness. /AIDS test results or diagno one year, unless revoked by id notice is received prior to the tather is the purpose of the purpose.	zation extends to all or any part of s, physical or sexual abuse, alcoholosis. I expressly consent to the releacy my written notice to Berks Eye is o release of the above-designated is was to obtain insurance. I further that receives it may re-disclose it. Prince	l/drug abuse, sexual se of information as Physicians & Surge nformation. I under understand that on	ly transmitted diseases, designated above. This cons, Ltd., at the above stand that I may not be ace the office discloses.
Patient or legally authorized individual signature			Date	
Patient is unable to sig	n because of:			
	Age of minor	or reason for patient's inability to sign	1.	
Printed name if signed	on behalf of the patient		Authority (parent, lega	al guardian, POA, etc.)