Berks Eye
Physicians & Surgeons, Ltd.

Medical Information Release Form

Patient Name: _____ Date of Birth: _____

I authorize the release of information including diagnosis, records, examination rendered and claims information to:

Spouse: _____

Child / Children: _____

Other: _____

☐ Information may NOT be released to others.

My Instructions for Message Notification

Please call: ☐ my home ☐ my work ☐ my cell phone

If unable to reach me:

☐ You may leave a detailed message on my answering machine.

☐ Please only leave a message asking me to return your call.

☐ _____

This release of information will remain in effect until terminated by me in writing.

Signature: _____ Date: _____