Berks Eye
Physicians & Surgeons, Ltd.

1802 Paper Mill Road
Wyomissing, PA 19610
Tel: (610) 372-0712 Fax: (610) 376-6968

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.

I hereby authorize the provider listed below (Name and Address) to release my records:

_____

_____

To disclose information from the medical/health records of patient:

Name: _____
Last First MI (Previous name)

Birthdate: _____ SS#: _____ Telephone: _____

Address: _____
Street City State Zip

This information is to be released to provider listed below (Name and Address):

_____

_____

Reason(s) for this authorization (Check all that apply):

☐ Second opinion ☐ Moving ☐ Changing physicians ☐ Continued coordinated care

☐ Ins. Change ☐ To have copy for self ☐ Other (specify) _____

Records should cover periods of healthcare (Dates of service):

From (date): _____ **To (date):**_____

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I understand and acknowledge that this authorization extends to all or any part of the records, designated above, which may include treatment for physical and mental illness, physical or sexual abuse, alcohol/drug abuse, sexually transmitted diseases, abortion, and/or HIV/AIDS test results or diagnosis. I expressly consent to the release of information as designated above. This consent is valid for one year, unless revoked by my written notice to Berks Eye Physicians & Surgeons, Ltd., at the above address, provided said notice is received prior to release of the above-designated information. I understand that I may not be able to revoke this authorization if its purpose was to obtain insurance. I further understand that once the office discloses. health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date

Patient is unable to sign because of: _____
Age of minor or reason for patient's inability to sign.

_____ _____
Printed name if signed on behalf of the patient Relationship & Authority (parent, legal guardian, POA, etc.)