TRI-CENTURY EYE CARE

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-Century Eye Care, PC is no longer responsible for the privacy of the released information. *There may be a charge for processing of records.*

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 _____

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