PHILADELPHIA EYE ASSOCIATES

Medical Records Request / Release

Patient Name: _____ Date of Birth: _____

Purpose of request:

- ☐ Request copy of records from Philadelphia Eye Associates
- ☐ Request previous medical records from an outside provider
- ☐ Specialist care
- ☐ Personal
- ☐ Transfer of my care
- ☐ Other: _____

Records to Be Released:

Please specify the information you would like released:

- ☐ Entire Electronic Medical Records
- ☐ Specific visit dates from _____ to _____
- ☐ Other: _____

The requested information described may be used and disclosed as checked below:

Release From / To	**Release From / To**
Philadelphia Eye Associates	_____
1930 South Broad Street	_____
Unit 9	_____
Philadelphia PA, 19145	_____
Fax: 215-271-3626	Fax: _____

This authorization expires: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in 180 days.

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By signing below, I acknowledge that once my information is release to a third party, it may no longer be protected under federal privacy regulations. I also understand that I am entitled to receive a copy of this authorization.

_____ _____

Patient or Legal Guardian Signature Date

_____

Relationship to Patient (Self/Parent/Guardian/Legal Representative)

Fax Medical records to Philadelphia Eye Associates at 215-271-3626