CHESTER COUNTY EYE CARE

(610) 696-1230
CHESTERCOUNTYEYECARE.COM

Authorization to Release Medical Information

Please fax completed form to (484) 723-2078.

Patient Information:

Name _____ Date of Birth _____

Address _____

City _____ State ____ Zip Code _____ Phone _____

Request Medical Information FROM:

☐ Chester County Eye Care | *915 Old Fern Hill Rd, Building B, Suite 200, West Chester, PA 19380*

☐ Other Physician/Practice Name _____

Address _____

City _____ State ____ Zip Code _____

Fax _____ Phone _____

Send Medical Information TO:

☐ Chester County Eye Care | *915 Old Fern Hill Rd, Building B, Suite 200, West Chester, PA 19380*

☐ Other Physician/Practice Name _____

Address _____

City _____ State ____ Zip Code _____

Fax _____ Phone _____

Please release the following medical information:

☐ Out-patient and in-patient records
☐ Presence in treatment/attendance
☐ Assessment, history, diagnosis, recommendations
☐ Psychiatric/Psychological/Psychosocial history and evaluation
☐ Other, specify _____
☐ Medical and psychiatric records
☐ Progress in treatment/progress notes
☐ Discharge summary and plans
☐ HIV/AIDS records

Reason for Release:

☐ Consult (1-2 years)
☐ Patient Move/Change of Physician (full chart)
☐ Other, please specify _____

This consent is subject to written revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate in twelve (12) months from date of client signature below.

I have carefully read and understand the above statements. I voluntarily consent to disclosure of the above information about, or records of my condition to the person(s) or agency(s) named above. I understand that my records are protected under Federal Law 42 U.S.C. 290 dd-2, Federal Regulation 42CFR Part 2, PA State Law 71P.S. 1690.108 (Act 63) and PA State Regulation 28 PA, Code Subsection 709.28 and 4 PA, Code Subsection 255.5 governing the Confidentiality of Alcohol and Drug Abuse Patient Records, and my records are protected by the Confidentiality of HIV Related Information Act 148.

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Signature of Patient or Legal Representative **Date**