WillsEye Physicians
Mid Atlantic Retina

☐ Bala Cynwyd, PA ☐ Bethlehem, PA ☐ Cherry Hill, NJ
☐ Huntingdon Valley, PA ☐ Lansdale, PA ☐ Marlton, NJ
☐ Mays Landing, NJ ☐ Newark, DE ☐ Newtown Square, PA
☐ Philadelphia, PA ☐ Plymouth Meeting, PA ☐ Wilmington, DE
☐ King of Prussia, PA ☐ Langhorne, PA ☐ NE Philadelphia, PA

MEDICAL INFORMATION RELEASE

Encounter number_____________________________ **Medical Record Number**________________________________
Date/Time Request Received____________________________

____ _______________________
PATIENT NAME DATE OF BIRTH

____ _______________________
PATIENT ADDRESS PHONE NUMBER

I authorize: _MID ATLANTIC RETINA______________ to release my Medical Records to: ___________________________

☐ **For the purpose of continuation of care**
☐ **For personal use**

Address: ___________________________________
____
____

Is the patient a minor? ☐ Yes ☐ No
If yes, are there any legal restrictions of your authority to act on behalf of the minor? ☐ Yes ☐ No
If yes, Legal documentation provided ☐ Yes ☐ No

Appt Date: _________________________________
Phone/Fax: __________________________

ATTENTION PATIENT

I understand & authorize the release of this information unless noted below as an exception.
I also understand that my record may contain:

- AIDS/HIV-related information, if AIDS/HIV-related tests were ordered by my physician
- Mental Health information, if mental health treatment was given by my physician
- Drug or alcohol information, if drug or alcohol tests were ordered or treatment was provided by my physician

Date(s) of Service ______________________________

☐ **REQUESTED ON ELECTRONIC MEDIA**

☐ Progress Notes
☐ Consultation reports
☐ Complete Medical Record
☐ Billing records/itemized statements
☐ Labs
☐ Photographs
☐ Other (please specify) ____
____
____

I understand that the provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

I understand that I may revoke this authorization at any time, in writing, except to the extent that Mid Atlantic Retina has already relied on it in making a disclosure.

My written revocation will become effective when Mid Atlantic Retina receives it. If I wish to revoke this authorization, I will send a written request to Mid Atlantic Retina, Privacy Officer, 4060 Butler Pike, Suite 200, Plymouth Meeting, PA 19462.

I understand that my authorization will remain in effect for a period of **1 year** from the date of my request or other specified date ______________________

____ ____
Patient's or Authorized Representative Signature/Date Printed Name and Relationship to Patient

Information released to: ____________________________ Date/Time: ______________________________
Information released by: ____________________________ Date/Time: ______________________________