MUDGIL EYE ASSOCIATES, PC

(610) 429-3004, FAX: (610) 429-3120

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Name of Patient:_____

Date of Birth: _____ **Telephone Number:** _____

Street Address:_____

City:_____ **State:** _____ **Zip Code:** _____

Date: _____

The specific information that I wish to have released is:

All Clinical Medical Records

o Other Records - Please list (e.g. billing, angiograms, photographs, etc.):

This medical record *may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.* Separate consent must be given before this information can be released.

o I consent to have the above information released.

o I do not consent to have the above information released.

Signature:_____ **Date:** _____

(Parent or Legal Guardian for Minors) **Relationship to Minor:** _____

Medical Records which *may contain information concerning HIV testing and/or AIDS diagnosis or treatment.*

Separate consent must be given to have this information released.

o I consent to have the above information released.

o I do not consent to have the above information released.

Signature:_____ **Date:** _____

(Parent or Legal Guardian for Minors) **Relationship to Minor:** _____

I understand that this authorization is valid for a _____ day period from the date that is signed.

I may revoke this consent at any time through written notice.

Release Records to:

Name:_____ **Telephone Number:** _____

Street Address 1: _____

Street Address 2: _____

City:_____**State:** _____ **Zip Code:** _____