Mudgil Eye Associates, PC

Adult & Pediatric Ophthalmology

(610) 429-3004 | Fax: (610) 429-3120

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Name of Patient: _____Date of Birth: _____

Email Address: _____Telephone Number: _____

Address: _____

City: _____State: _____Zip:_____

The specific information that I wish to have released is:

☐ All Clinical Records

☐ Other Records – Please specify (e.g. billing, angiograms, photographs, etc.):

Signature _____ Date _____

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

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

☐ I consent to have the above information released.

☐ 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 90 days period from the date of that is signed. I may revoke this consent at any time through a written notice.

Release Medical Information **FROM**:

☐ Mudgil Eye Associates, PC | 795 East Marshall Street, Suite 103, West Chester PA 19380

☐ Practice Name_____

Address: _____

City: _____State: _____Zip:_____

Phone: _____ Fax: _____ Email: _____

Release Medical Information **TO**:

☐ Mudgil Eye Associates, PC | 795 East Marshall Street, Suite 103, West Chester PA 19380

☐ Practice Name_____

Address: _____

City: _____State: _____Zip:_____

Phone: _____ Fax: _____ Email: _____