WILLS EYE OPHTHALMOLOGY CLINIC

840 Walnut Street
Philadelphia, PA 19107-5109
Medical Records: 215-928-3093
Fax: 215-825-9086

Medical Records #:

Patient Name (Please Print):
DOB: **Phone #**
Address

I hereby authorize Wills Eye Ophthalmology Clinic to furnish information from my medical records
Name of Person or Institution:

For the purpose of:

I authorize the above named source to release of disclose the following information. Any medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome(AIDS) or testing for HIV;

This information is protected from further disclosure by state and/or federal laws.

Information to be released: **Dates to be released:** **to**
Type(s) of Service

Inpatient	**Discharge Summary**	**EEG**	**EKG**
Outpatient	**History & Physical**	**DSU**	**Operative Report**
Lab Report	**Pathology Report**	**ER**	**Radiology**

Other (please specify)

This authorization to release patient information will expire 90 days after it is signed, unless revoked by written request. IF the patient is physically unable to sign (e.g., a minor legally incompetent, or deceased) the parent next of kin must sign below. Two signatures required for verbal consent only.

Date: __________ Signed: ______________________________

Date: __________ Signed: ______________________________

If not patient, please check appropriate space
Parent ____ Guardian ____Executor of Estate____Witness____