Medical Records Dept. Fax# 215-825-9086
Email: medicalrecords@willseye.org

Release of Information Authorization

Patient name: ______________________________ Date of Birth ______________________________

Full address: ______________________________ Phone number: ______________________________

Authorization to release records to Wills Eye

I, ___________________________ authorize any physician, nurse, or other healthcare professional who has treated me, or any hospital at which I have been confined to, to furnish to: **Wills Eye - 840 Walnut Street, Philadelphia, PA 19107** or an authorized representative, any and all information that may be requested regarding my physical or mental condition and treatment rendered therefore and, if necessary, to allow them or a physician appointed by them to examine any x-ray pictures taken of me, test results, or records regarding my physical or mental condition or treatment. In addition, I also authorize the release of any psychiatric / psychotherapy records, mental health records, and drug and alcohol treatment information under the same terms and conditions.

A photocopy of this instrument may be used instead or the original.

______________________________ ______________________________

Patient Name / Guardian / Agent Date

______________________________ ______________________________

Patient / Guardian / Agent Signature Relationship

Authorization for Wills Eye to release records

Please specify the information to be released: ______________________________

I understand that information in response to this request may be related to testing of AIDS/HIV, whether the result is negative or positive, treatment for drug and alcohol use/abuse, and psychiatric care or treatment.

Information Provided to: ______________________________

Name of Person / Institution Telephone Number

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Full Address: Street/City/State/Zip Code Email address or fax number to send records to:

Purpose of the Request Information: ______________________________

This authorization expires: ______________________________

If I fail to specify an expiration date, event or condition, this authorization will expire in 180 days.

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I hereby authorize Wills Eye Hospital and its controlled affiliates (collectively known as "Wills") to disclose the health information described above. I understand that I may revoke this authorization at any time by written request made to the Privacy Officer at Wills Eye except to the extent that action has been taken in reliance on this authorization. My refusal to sign this form will not affect my treatment, except when I have requested a service by Wills and the purpose of the service is to provide health information to a third party at my request. It is possible that information disclosed under this authorization might be disclosed by the recipient and no longer be protected. This form has been fully explained and I certify that I understand its contents.

______________________________ ______________________________

Patient Name / Guardian / Agent Date

______________________________ ______________________________

Patient / Guardian / Agent Signature Relationship