Quakertown Eye Associates, P.C.
500 Juniper Street, Quakertown, Pennsylvania 18951
Phone: 215-536-5583 Fax: 215-536-8640
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Authorization for Disclosure of Health Information

Patient Name	Date of Birth

Full Address: Street/City/State/Zip

Telephone Number	Social Security Number **(last 4 digits only)**:

Disclosed Information *(check all items to be released)*

☐Abstract (Pertinent information) ☐Copies of Prescriptions
☐Copies of Exams ☐Copies of Testing
☐Entire Record
☐Other (please specify): _____

☐Covering the periods of care: From _____ to _____ ☐All Dates

Information Provided ☐TO / ☐FROM

Name of Person or Institution	Telephone Number

Full Address: Street/City/State/Zip

Purpose/Use Of The Requested Information

☐Personal use by the patient ☐Sharing with other health care providers
☐Transfer of care ☐Other (please describe): _____

Authorization Expires

☐1 year from date of authorization ☐Other Date (please specify): _____
☐Event (please specify): _____

If no expiration date is designated this authorization will expire six (6) months from the signature date.

Authorization

• I hereby authorize _____ to disclose the health information described above.

• I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing.

• I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Print Name **Relationship of Personal Representative to Patient**

If Authorization is signed by someone OTHER than the patient, please state the reason:

_____

_____