RELEASE OF INFORMATION

Patient Name (print)	Date of Birth	Social Security #

Maiden Name or Previous Name	Parent(s) Name if Minor

I HEREBY AUTHORIZE THE RELEASE OF MY INFORMATION TO:

LEHIGH EYE SPECIALISTS
1251 S CEDAR CREST BOULEVARD, SUITE 307
ALLENTOWN, PA 18103
FAX: 610-820-8376

This information can be released as instructed, including medical documentation, opinion, or assistance about reports, records, or x-rays, or any other information or documents that you may have in your custody or in your control, with reference to me. I understand that electronic medical records will be provided on a USB hard drive. Please note that this USB drive is NOT encrypted. Take care not to lose or misplace it as this contains your personal medical information.

I specifically authorize the following to be released. This confidential information is protected by Federal and/or State Law. *Please indicate YES or NO and please initial for your authorization.

_____ Mental Illness Information
_____ Aids or HIV- related Information
_____ Drug or Alcohol Abuse Information

The purpose of this disclosure is: _____ Medical Care _____ Insurance Purpose_____ Other _____

Patients Signature	Date

Patient/Legal Representative Signature (if appropriate)

This waiver expires one year after the date hereof. I understand that I may revoke this authorization at any time by giving written notice.
*Note: Re-disclosure or this information without further written consent is prohibited. The receiver may NOT further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
A photocopy or facsimile of this authorization, as duly executed, shall have the same force and effect as this original.