Bailey Weber Wisner

MEDICAL RECORDS RELEASE AUTHORIZATION

DATE: _____

TO: _____
DOCTOR/FACILITY

_____
ADDRESS

_____
CITY **STATE** **ZIP CODE**

_____
PHONE **FAX**

Please release my medical records to:

Wills Eye Physicians Bailey Weber Wisner
4060 Butler Pike Suite 100
Plymouth Meeting, PA 19462

Phone: 215-836-1290 Fax: 215-233-3421 Surgery Department Fax: 215-836-1291

Please include the following heightened confidential treatment information (check all to be included):

- ▫ **HIV/AIDS**
- ▫ **Drug Abuse**
- ▫ **Mental Health**
- ▫ **Sexually Transmitted Diseases**
- ▫ **Alcohol Abuse**

Note: Unless the above specific information is checked to be released, in most instances, it will be removed from the records being sent.

NAME OF PATIENT: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

_____

PATIENT'S SIGNATURE: _____ _ **DATE:**_____