AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Bucks County Eye Group
Barry Oppenheim, M.D.
842 Durham Road Suite 7
Wrightstown, PA 18940

*Patient Name:*_____ *Birth Date:*_____

_____
Full Address: Street/City/State/Zip

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

Information Provided To:

_____ _____
Name *Relationship to patient*

_____
Full Address: Street/City/State/Zip

_____
Telephone Number

X_____ _____
Patient Signature *Date*

X_____ _____
Signature of Person Authorized if Minor *Relationship to Patient*

X_____ _____
Witnessed by *Date*

☐ *Glass and contact lens prescription only (no charge)*

_____
Office use only

*Date release received*_____ *Date patient notified*_____

*Pickup date*_____ ☐ *(mailed)*

Glass and contact lens prescriptions

If you would like to obtain a copy of your most recent glass and or contact lens prescription at no charge please contact the office:

By phone (215-598-0120). We will call you back when the prescription is ready to be picked up. Please bring this signed release with you to the office.

By fax (215-598-0123). You can fax a signed release to our office. We will call you back when the prescription is ready to be picked up.

By mail. You can mail a signed release to our office. We will call you back when the prescription is ready to be picked up.

*If you would like to have the prescription mailed to you please mail a signed release to our office along with a self addressed stamped envelope.

**If the record release is for a patient who is now over the age of eighteen years old, regardless of the age they were last seen, we require the patient's signature on the record release form.

***Unfortunately we cannot process requests by unencrypted email due to HIPAA.