



I AUTHORIZE MY RECORDS TO BE RELEASED TO:

- Richard L. Jahnle, M.D.
- Kelly L. Krespan, M.D.
- Edward J. Mekel, O.D.
- Vanessa Vilorio, O.D.
- Erika Saucedo, O.D.

PLEASE SEND RECORDS TO:

_____ 2010 West Chester Pike, Suite 310
Havertown, PA 19083
Phone: 610-446-2260
Fax: 610-446-3360

_____ 1098 West Baltimore Pike, Suite 3407
Media, PA 19063
Phone: 610-566-7127
Fax: 610-566-0793

Patient's Name _____
(Please Print)

Patient's Date of Birth _____

Patient's Address _____

Patient Signature _____ Date: _____

By signing this form, I hereby authorize the doctor/practice/facility listed below to release confidential health information to Jahnle Eye Associates.

Signature of Witness _____ Date: _____

Records Released From:

Name _____

Address _____

Phone/Fax _____

- Please send: Examination IOL Powers Pre & Post Op- Ks
 Testing Testing in color