



**I AUTHORIZE MY RECORDS TO BE RELEASED TO:**

- Richard L. Jahnle, M.D.
- Kelly L. Krespan, M.D.
- Edward J. Mekel, O.D.
- Rocio C. Pasion, O.D.
- Nestor Biletsky, O.D.
- Hugo M. Linares, D.O.

**PLEASE SEND RECORDS TO:**

\_\_\_\_\_ 2010 West Chester Pike, Suite 310  
3407

Havertown, PA 19083  
Phone: 610-446-2260  
Fax: 610-446-3360

\_\_\_\_\_ 1098 West Baltimore Pike, Suite

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