Jahnle EYE ASSOCIATES

RECORDS RELEASE FORM

Name _____
(Please Print)

Date of Birth _____

Address _____

_____

_____

Patient Signature _____ Date: _____

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

I AUTHORIZE MY RECORDS TO BE RELEASED TO:

Name _____

Address _____

Phone _____

Fax _____

E-Mail _____

Please send: ❒Examination ❒ IOL Powers ❒ Pre & Post Op- Ks
❒ Testing ❒ Testing in color **Please allow additional days to release color images.*