Jahnle
EYE ASSOCIATES

I AUTHORIZE MY RECORDS TO BE RELEASED TO:

❒ Richard L. Jahnle, M.D.
❒ Kelly L. Krespan, M.D.
❒ Melvin I. Roat, M.D.
❒ Edward J. Mekel, O.D.
❒ Zachary Tlumak, O.D.
❒ Kelly Moritz, 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