Moran Eye Associates, P.C.
1204 Delaware Avenue
Bethlehem, PA 18015

o: 610-628-2022
f: 610-628-4966

e: info@moraneyeassociates.com
w: www.moraneyeassociates.com

Consent to RELEASE or OBTAIN Medical Records

Patient name: ____ Birthdate:____________

Address:____

I authorize Moran Eye Associates, to obtain my medical records from:

Lehigh Valley Center for Sight
1739 Fairmont Street
Allentown, PA 18104

I have read and fully understand the nature of this authorization to release information. I understand that I may revoke this consent at any time, but that any such revocation would not be applicable to record released on the authority of this signed consent prior to the date of the revocation.

Patient Signature:______________________________________ Date:_____________________