Berkeley Heights Eye Group, P.A.

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AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

PATIENT NAME: _____ DATE of BIRTH: _____

ORGANIZATION RECEIVING RECORDS: _____

ADDRESS: _____ PHONE:_____

ORGANIZATION SENDING RECORDS: _____

ADDRESS: _____ PHONE:_____

Please select ONE of the following:

- € I would like my entire medical records and tests.
- € I would like medical records and tests from the dates ___/___/____ (MM/DD/YR) to ___/___/____ (MM/DD/YR)

PURPOSE of DISCLOSURE (circle one): Referral / Ongoing Patient Care / Patient Request / Litigation

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be redisclosed by the recipient.

To the extent any of the following information is contained in my records being released; I specifically authorize the release of such information for the purposes indicated below by initialing below each category:

HIV/AIDS testing, test results, treatment and related information including high information; drug and/or alcohol diagnosis, test results, treatment, and reports and referral information; mental health treatment information, test results, and reports including psychological and psychiatric studies, reports, evaluations and referral information; venereal disease information; genetic testing, test results, counseling, reports, treatment, and referral information.

INITIAL: _____

You must read and initial the following statements:

1. INITIAL: __ I understand this authorization will expire on ___/___/____ (MM/DD/YR), or on the following event: Termination of the Physician/Patient Relationship
2. INITIAL: __ I understand that I may revoke this authorization at any time, except to the extent information has already been released in response to this authorization.

_____ _____

SIGNATURE of PATIENT or REPRESENTATIVE DATE

_____

RELATIONSHIP TO PATIENT