Berkeley Heights Eye Group, P.A.

571 Central Ave, Suite 101 P: (908) 464-4600

New Providence, NJ 07974 F: (908) 464-4737

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name: _____ **DOB:** _____

To: _____

Telephone #: _____ **Fax #:** _____

I, _____ hereby authorize the use or disclosure of my
Patient Name

individually identifiable health information to the organization 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.

Organization Name: _____

Telephone #: _____

Fax #: _____

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 before each category:

INITIAL: ____ 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.

Reason for Request (circle one): Referral/ Ongoing Patient Care/ Patient Request/ Litigation

Specify Information Required (Include Date Range):

_____

_____

Signature of Patient or Representative: _____ **Date:** _____

Relationship to Patient: _____