AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Doctor's Name ____

Doctor's Address ____

Doctor's Phone/Fax Number ____

Patient Name ____DOB _______________

Patient Address ____

Patient Phone Number ____

I authorize the health care professional/facility named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) or recipients]:

   Advanced Eyecare Associates
   Randolph Brooks, O.D., Lic. # OA00375200
   Susan M. Gardner, O.D., Lic # OA00481600
   Danielle Gaeta, O.D., Lic. # OA00659700
   410 Route 10, Suite 202, Ledgewood NJ 07852
   Phone: 973-584-2020 Fax: 973-584-4992

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person, Mrs. Diane Heiskanen.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated ______________________ Patient Signature _____________________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form: ________________________________

Revised September 2015