THE EYE CLINIC NJ
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Patient Name_____ Date of Birth_____ Last 4 digit SS#_____

Address_____ City_____ State_____ Zip_____

Phone #_____ Email_____

I hereby authorize The Eye Clinic NJ to release my protected health information in the manner listed below, and to the following:

Send by: (choose ONE): ☐ **Mail** ☐ **Fax** ☐ **Secure Email**

Send to:

Name:_____

Address_____ City_____ State_____ Zip_____

Phone#_____ Fax#_____ Email_____

Please send:

☐ **All Records (Notes, Labs, Reports, CD)**

or

☐ **Specific Item Only** (please list):_____

Depending on your request, it can take 2-3 weeks to receive records, though most requests are fulfilled sooner

This authorization will not expire except when revoked by the patient, legal guardian, power of attorney, or healthcare surrogate. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written request to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under federal privacy laws or regulations. I understand LSI will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

_____ _____

Signature of Patient/Guardian/Power of Attorney/Healthcare Surrogate Date

_____ _____

Printed Name Relationship to Patient if Applicable