Authorization of Release of Health Information and Records:

I hereby authorize the release of my protected health information and records (including, if applicable, the release of information about substance abuse treatment, mental health service and HIV infection or AIDS). I understand this authorization is voluntary. I understand that any and all records, whether electronic, written or oral format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand a fax copy of this authorization is as valid as the original.

RECORDS TO BE DISCLOSED AND RELEASED FROM:

Doctor's Name_____

Doctor's Address_____

Doctor's Phone_____Fax_____

Patient Name:_____ Date of Birth:_____

Patient Address:_____

Patient Phone Number:_____

Description of information to be released: **All records including Exam Writer records and billing records**

RECORDS TO BE RELEASED TO:

VISION SOURCE® OF MT. OLIVE

MICHAEL J. SIEGEL, O.D. LIC#OA5118

135 Rt. 46 E., Unit E, Paramount Plaza * Budd Lake, NJ 07828 * 855-948-2020

Please send an electronic copy of patient's records to help preserve the environment

Info@VisionSourceMtOlive.com or fax to: 973-527-7964

I understand that I can revoke this authorization at any time by notifying the office in writing. I also understand the revocation does not apply to information already released in response to this authorization. I have read and understand this form.

Patient Name:_____Date:_____

Patient Signature:_____

If patient is a minor, or you are signing as a representative or guardian of the patient, please sign below:

Print Name:_____Relationship to patient:_____

Representative/Guardian signature:_____