<u>Authorization for Release of Medical Record Information</u>

Patient Name: ____ DOB: _________________

Street Address: ____

City: ______________________________ State: ____________ Zip Code: ______________

From: Pediatric Eye Associates, LLC
22 Old Short Hills Road, Ste. LL-1
Livingston, NJ 07039

To : ______________________________

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☐ All Clinical Records

☐ Other Records – Please List (i.e. billing, photographs, etc.)

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Patient / Parent / Guardian's Printed Name: ____________________________________

Patient / Parent / Guardian's Signature: ____________________________________

Date: ________________

I authorize that my protected health information (PHI) be disclosed by Pediatric Eye Associates (PEA) to the individual or entity indicated above. I understand that the PHI, which is used or disclosed pursuant to this Authorization, may be subject to re-disclosure by the recipient and that PEA has no control over the PHI disclosed to the individual or entity indicated above. I understand that I am under no obligation to sign this Authorization and that this authorization will expire 120 days after the date I signed it. This Authorization may be revoked, in writing, at any time. My signature above indicates that I have read and understand this Authorization and that I give my authorization to PEA to disclose PHI in accordance to the terms of this Authorization.