

Please email this completed form to: [contact@kideyedoc.com](mailto:contact@kideyedoc.com)

**Authorization for Release of Medical Record Information**

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

All Clinical Records

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

\_\_\_\_\_  
\_\_\_\_\_

**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.