Studio 2020 Vision Care, LLC
2130 Highway 35, Suite 111
Sea Girt, NJ 08750

AUTHORIZATION FOR RELEASE

MEDICAL RECORD INFORMATION TO THIRD PARTY

Patient Name:_____ __ ____ Date of Birth:_____ _____
Phone: H) _____ Phone: W) _____
Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

The above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: Studio 2020 Vision Care Facility Phone: 732-449-2121

Facility Address: 2130 Highway 35, Suite 111 Facility Fax: 732-449-8915

City, ST, Zip: Sea Girt, NJ 08750

Dates and Type of information to disclose:

_____

_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____

Fax: _____ Phone: _____

____Please mail records.

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____ Please fax records.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____

Signature of Patient / Parent / Guardian or Authorized Representative Date (Guardian or Authorized Representative must attach documentation of such status.)

_____

Date

_____ _____

Printed name of Authorized Representative Relationship Capacity to patient

_____

Address and telephone number of authorized representative