EyeSite Vision Center

1126 Washington Street
Hoboken, NJ 07030
Tel: (201) 659-3724

AUTHORIZATION FOR RELEASE OR OBTAINING HEALTH INFORMATION
THIS IS TO AUTHORIZE:

☐Release my Eye Exam information records To:
☐Obtain my Eye Exam Information Records From :

NAME OF AGENCY OF PERSON		TITLE
STREET ADDRESS		APT #
CITY	STATE	ZIP CODE
TELEPHONE #	FAX #	

To assist in identification and location of my Health Information Record, I am providing the following information (Please Print)

Name: _____
First Last

Address: _____
Street City State Zip Code

This authorization will remain in effect for six months after I sign and date from below. I understand that no principal, doctor or employee of this office shall be held responsible for any error or complication arising from the use of this record at any other facility.

Signature of Patient _____ Date_____
(If minor, Signature of parent and/or Legal Guardian)

Fee schedule For patients and Attorneys: No. of pages____ x $1.00 per page = Total Fee_____ Written Report: $30.00 per report

Office use only: Date Copies Provided/Mailed: ___/___/___
Name of Staff:_____

*Note: after submitting the completed form, it may take up to 45 days to process.