Patient Authorization to DIsclose Protected Health Information

Fields Of Vision
1872 Route 88
Brick, NJ 08723
732-458-7808

I, _____, authorize Dr. Field to disclose any of my protected health information by Fields of Vision. I understand this request applies only to communications from Fields of Vision or Dr. Field to those listed below.

Please indicate the individuals that we are permitted to discuss your patient information below

Individuals I would like to allow Fields of Vision to discuss my information with:

Individual's Name:_____

Individuals address and phone_____

_____

Other individuals, opticals or medical professionals_____

_____

Note: this request will remain in effect until you notify us of a change in writing

Signature:_____ Date_____

Printed name_____
Relationship (if not patient)_____

**Patient date of birth: / / **Last four digits of social security_____

☐ **I do not authorize sharing my personal health information with anyone**

Signature:_____ Date_____

Printed name_____
Relationship (if not patient)_____

**Patient date of birth: / / **Last four digits of social security_____