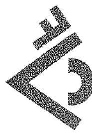

Family Vision Care Associates, LLP

Ira J. Bernstein, O.D., F.A.A.O., F.C.O.V.D.   Paul R. Bernstein, O.D., F.C.O.V.D.   Andrea S. Bernstein, O.D.

AUTHORIZATION TO RELEASE OR OBTAIN PRIVATE HEALTH INFORMATION

Patient's Name: ______________________________

Address: ______________________________

Telephone No.: ______________________________

Date of Birth: ______________________________

This is to authorize:

___ photocopy of records

___ release of records by telephone

___ release of records by facsimile

___ obtain records

___ other: ______________
____

Person/Agency from whom the information is to be obtained:

Name/Agency: ______________________________

Address: ______________________________

Phone: ______________ *Fax:* ______________

Person/Agency to whom the information is to be sent:

Name/Agency: ______________________________

Address: ______________________________

Phone: ______________ *Fax:* ______________

Patient's / Legal Guardian's Signature: ______________________________

Date: __________

701 Westchester Avenue White Plains, NY 10604

(914) 948-0304 (914) 948-0365 Fax