Authorization to Disclose Medical Information

Patient Name: _____ Chart#: _____

Birthdate: _____ Date: _____

Address: _____

Permission to Disclose Medical Information *(Must be completed by a parent/guardian if the patient is under the age of 18)*

I give permission for South Jersey Eye Physicians, PA to discuss medical information for the above named patient, including examinations and test results with the following friends or family members. If left blank, information will only be given directly to the patient (or parent/guardian if under age 18).

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

This authorization will remain in effect at South Jersey Eye Physicians, PA until it is either revoked or changed.

This document is authorized and signed by ☐ self (patient) ☐ parent ☐ guardian

_____	_____
Signature	Printed name