SILVERSTEIN Eye, *a division of Niki Silverstein MD, LLC*

Authorization to Release Medical Records

I_____, give permission to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information to **SILVERSTEIN Eye**, ***a division of Niki Silverstein, MD, LLC.*** At this time I am requesting the following:

_____ Complete record

_____ Records of care from: _____ to _____ only

_____Records of care concerning the following condition(s)
_____

_____

____Other - Specify:
_____

____Confer with other person really about information in my medical record.

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records. Initial_____ Date_____

to the following person(s):

SILVERSTEIN Eye
a division of Niki Silverstein, MD, LLC
408 Main Street
Chester, NJ 07930

I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application has been filed or is pending.

Signed: _____ Date: _____

_____
(Patient or person legally authorized to consent on patient's behalf)

Vision to Lead.