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

408 Main Street
Chester, NJ 07930
Phone: 908.879.7297
Fax: 908.879.4798

RELEASE OF CONFIDENTIAL INFORMATION

I, _____am aware that **SILVERSTEIN Eye, *a division of Niki Silverstein, MD, LLC*** holds my medical information as confidential. My medical care and test results cannot be disclosed or discussed with anyone but myself. I understand that my medical information may be released to a family member, friend or other person I indicate is involved in my care only if they are listed below. This permission will stand unless changed by myself. I understand that this is my responsibility to forward any changes in writing and verbal changes will not be honored.

SILVERSTEIN Eye, *a division of Niki Silverstein, MD, LLC* may leave information for me on my answering machine or voice mail. (Please check "yes" or "no" below.)

Home: Yes_____ No_____ Work: Yes____ No____

Name: _____ Phone #:_____

Relationship_____

_____

_____

_____

_____

_____

I understand this information will stay in my permanent medical record unless I give written notice otherwise

_____
Patient Name or Responsible Party Signature

_____ Date: _____
Responsible Party's Relationship to Patient

Vision to Lead.