Matthew Kelleman, OD

Board Certified Optometric Physician

36 North Main Street

Milltown, NJ 08850

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to disclose my protected healthinformation to Dr. Matthew Kelleman and his staff.

This authorization for release of information covers the period of healthcare  from:

a. □ all past, present, and future periods

b. □ or from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of my complete health record

□ with the exception  of the following information

(please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This medical information may be used by Dr.Kelleman for medical treatment or consultation. It will become part of my record and protected under the Health Insurance Portability and Accountability Act.

I understand that I have the right to revoke this authorization, in writing,  at any time.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient or patient representative