Changmin Duan O.D. P.A.
East Brunswick Professional Park
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East Brunswick, NJ 08816
Tel: (732) 247-2847
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AUTHORIZATION FOR RELEASE OR OBTAINING HEALTH INFORMATION
THIS IS TO AUTHORIZE

_____ Release my Eye Exam Information records to:

_____ Obtain my Eye Exam Information Records from:

_____
NAME OF AGENCY OR PERSON TITLE

_____
STREET ADDRESS APT#

_____
CITY STATE ZIP CODE

_____
TELEPHONE # (INCLUDE AREA CODE)

To assist in identification and location of my Health Information Record, I am providing the following information (please print)

NAME_____
First Last Maiden

ADDRESS_____
Street City State Zip Code

This authorization will remain in effect for six months after I sign and date form below. I understand that no principal, doctor or employee of this office shall be held responsible for any error or complication arising from the use of this record at any other facility.

Signature of Patient Date
(if minor, guardian)

Fee Schedule For patients and Attorneys: No. pages____ x $1.00 per page = Total Fee_____
Written Report: $30.00 per report

Office use only: Date Copies Provided / Mailed ____/____/____ Name of Staff_____