ADVANCED EYECARE
A MEMBER OF VISION SOURCE

HILLSBOROUGH
EDGEWATER
CARTERET

RECORDS RELEASE FORM

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

Patient Full Name:			Date:
Address:			DOB:
City:	State:	Zip:	Phone:

AUTHORIZATION DIRECTION

I hereby authorize the release of my medical to:

Name/Facility:	Phone:
Address:	Fax
Email:	

To be released from the following Advanced Eyecare location:

☑ *Select locations:* ☐ Advanced Eyecare of Hillsborough ☐ Advanced Eyecare of Edgewater ☐ Advanced Eyecare of Carteret

Signature:	Date:

Advanced Eyecare of Hillsborough
305 Omni Drive
Hillsborough, NJ 08844
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Advanced Eyecare of Edgewater
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edgewatereyecare.com

Advanced Eyecare of Carteret
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