Douglas Kelley, O.D.
Galloway, NJ 08205
609-748-2288

Consent for Release of Information
Responsibility for Patient.

I consent to the use and disclosure by the Office any information, e.g. health information Concerning my vision examinations and products, to any party and or agent, including, Treatment, the payment of my vision benefit claims, and related customer Communications regarding health care services provided by the Office (e.g. mailings of exam reminder/recall cards or explanations of service/ products provided by the Office).

If I desire to seek third party reimbursement for the services received, I authorize the Office to submit a vision benefit claim for payment to any third party as identified. I understand that I am responsible for all changes incurred, including any portion not paid by any third party.

I understand that this consent for release of information is voluntary and I may revoke my consent at any time by notifying the Office in writing, except for any disclosure already taken in reliance of my consent to release of information. I understand that I may request the Office to restrict the use and disclosure of my information, however, the Office is not required to agree to my request.

I acknowledge that I have received and understand the pamphlet "Protecting Your Health Information."

Please be advised that if you are a contact lens wearer, there normally is an additional charge, whether you are using an insurance company or not for the routine exam. If you have any questions, please ask before the examination.

____________________________________ ____________________
Signed (patient or legal representative) **Date**

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Legal Representative's relationship