

Date:

Patient Name:

DOB:

I, \_\_\_\_\_ hereby authorize release of my medical records to  
the Low Vision Center of Central New Jersey.

Signature: \_\_\_\_\_

Please mail or fax the reports to:

Bethany Fishbein, OD  
Jonathan Fishbein, OD  
Low Vision Center of Central New Jersey  
37, Clyde Road  
Somerset NJ 08873  
Phone: 732-568-0038  
Fax: 732-568-0041