Total EyeCare and Aesthetics
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## **Notice information Release**

I give permission to Total EyeCare and Aesthetics to speak with the following person/people regarding my care and treatment within the practice.

I understand that my information may include (but is not limited to) diagnoses, medication, pre or post operative information, plan of care, treatment options, and appointment information.

Name:	
Relationship to patient:	
Patient Name (printed) and date	
Patient Signature	

The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.