

**Lederman and Lederman, LLP
Pediatric Ophthalmology
Strabismus**

Martin E. Lederman, M.D., F.A.C.S.
Carolyn R. Lederman, M.D.
Gennifer J. Greebel, M.D.

3020 Westchester Avenue, Suite 201
Purchase, NY 10577
Tel: 914-417-6441
Fax: 914-948-2020

Edward S. Harkness Eye Institute
New York Presbyterian Hospital
635 West 165th Street
New York, NY 10032

Website: www.ChildrensEyeMD.com
Email: Doctors@ChildrensEyeMD.com

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By signing this, I am allowing Lederman and Lederman, LLP to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior request.

Signature of Patient, Parent or Legal Guardian

Patient's Name

Date

Print Name of Patient, Parent or Legal Guardian