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187 NJ-36, Suite 230

West Long Branch, NJ 07764

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |
| --- | --- |
| Patient’s Name:  | Date:  |
|  |  |
| Date of Birth:  | Social Security #:  |

I request and authorize to release healthcare information of the patient named above to:

|  |  |  |
| --- | --- | --- |
| Name:  | ­Phone:  |  |
| Address:  | Fax: |  |
| City:  | State:  | Zip Code:  |

|  |  |  |
| --- | --- | --- |
| I authorize this information to be faxed (when applicable) |  Yes |  No Client Initials:  |

|  |
| --- |
| This request and authorization applies to (check below):  |
|  Healthcare information relating to the following treatment, condition, or dates:  |
|   Other: |
|  |

Authorization re: sensitive information: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, such information about me will be released if it exists.

|  |  |  |
| --- | --- | --- |
|  HIV/AIDS |  Genetic Information |  Treatment for alcohol and/or drug abuse |
|  Mental Health  |  Sexually Transmitted Disease(s) |   |

Without my express revocation, I understand that this authorization will expire in one (1) year from the date signed unless indicated below:

* Under the following condition(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Upon satisfaction of the need for disclosure
* On\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*enter a future date other than date signed by patient not to exceed 1 year)*

I understand that once my medical records leave this practice, there is a potential for redisclosure by the recipient if they are no longer protected by the Privacy Rule.

I may revoke this authorization in writing but any previously disclosed information would not be subject to such revocation. I may inspect or copy the information to be used or disclosed and may refuse to sign the authorization. My refusal to sign will not affect my ability to obtain treatment, payment, enrollment or my eligibility for benefits, unless otherwise described in the space provided here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Patient Signature:  | Date Signed:  |
| Parent/Legal Guardian Signature:  | Date Signed:  |
| Personnel Signature:  | Date Signed:  |