Hackensack University Medical Group Primary Care

Forest Healthcare Associates, P.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION PURSUANT TO PATIENT REQUEST

I, _____, authorize the release of my entire medical record or, if the following section is completed, only such portion of my medical records as is specifically described:

_____

Please release my medical records to:

Name: _____

Address: _____

_____

If this Authorization relates to someone other than the person signing it, indicate the name of the patient whose records are requested as well as proof of Power of Attorney:

_____

I understand that the records you release may contain information pertaining to the following:

*Drug & Alcohol abuse information
*HIV information, including lab results
*Diagnosis of sexually transmitted diseases
*History & Physical
*Routine consultations/examinations
*Genetic testing and counseling
*Results of diagnostic testing
*Mental health information
*Treatment recommendations

I understand that if I do not want any of the above information released, I may limit your Authorization to release such information by crossing it out and initialing it. If there is other information that I specifically DO NOT want released, I should identify it in the following space:

If none, write "None":_____

Purpose/Use of Information Requested: The information requested will be used for my own purposes or if not, then it will be used for the following:

_____.

Right to Revoke Authorization: I understand that I may revoke this Authorization at any time by notifying you in writing at the address listed in the letterhead. I understand that if you have already released information or otherwise acted in reliance upon this Authorization, that any subsequent revocation will not affect the validity of your prior disclosure or other action.

Termination: If not revoked by me sooner, this Authorization will terminate on: _____. If a date is not provided, then this Authorization will be terminated in one year from the date it was authorized.

Right to Inspect Information: I understand that I have the right to inspect the information to be disclosed.

_____ _____
Name (print) Witness (signature)

_____ _____
Daytime Phone Number Alternate Phone Number

_____ _____
Date of Birth Social Security Number

_____ _____
Signature Date

Are your medical records being transferred to a new primary care physician?_____