

## Authorization for Release of Information

PATIENT NAME: LAST  FIRST  MI  MAIDEN OR OTHER NAME   
DATE OF BIRTH:  -  -  SS#:  -  -  MEDICAL RECORD #:   
MO DAY YR

ADDRESS:  CITY:  STATE:  ZIP:   
DAY PHONE:  EVENING PHONE:

I hereby authorize Englewood Orthopedic Associates to release information from my medical record as indicated below to:

NAME:   
ADDRESS:  CITY:  STATE:  ZIP:   
PHONE:  FAX:

### INFORMATION TO BE RELEASED:

DATES:

History and physical exam   
 Progress notes   
 Lab reports   
 X-ray reports   
 Other:

I specifically authorize the release of information relating to:

Substance abuse (including alcohol/drug abuse)  
 Mental health (including psychotherapy notes)  
 HIV related information (AIDS related testing)

X SIGNATURE OF PATIENT OR LEGAL GUARDIAN  DATE

PURPOSE OF DISCLOSURE:  Changing physicians  
 Legal  School  
 Other (please specify):

Consultation/second opinion  
 Insurance

Continuing care  
 Workers Compensation

1. I understand that this authorization will expire ninety (90) days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by  (Print Name of Provider) for the purpose of:  
  
a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.  
b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.  
c. I have been informed that  (Print Name of Provider)  will/  will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with New Jersey statute, I will pay a fee of \$  . There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

OR

SIGNATURE OF PATIENT  DATE  PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

RECORDS RECEIVED BY  DATE  RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

BY:

FEE COLLECTED: \$

RESET