

Authorization to Release Medical Record (page 1 of 2)

Patient name: _____ Date of Birth: ____/____/____

Address: _____

Phone number: _____ Email: _____

I hereby authorize Colorectal Care of New Jersey LLC to release my medical records to:

I hereby authorize Colorectal Care of New Jersey LLC to obtain my medical records from:

I am requesting my records to be disclosed to:

Name of person or entity: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

The purpose of my request is for:

<input type="checkbox"/> Sharing with other health care provider(s)	<input type="checkbox"/> Personal record	<input type="checkbox"/> Attorney/Legal
<input type="checkbox"/> Social service/ disability	<input type="checkbox"/> Other: (please specify)	

Please forward my requested records by the selected method:

<input type="checkbox"/> Mail to recipient address	<input type="checkbox"/> Pick up at Practice by myself (patient)
<input type="checkbox"/> Fax to recipient	<input type="checkbox"/> Pick up at Practice by below person who is authorized by me:
<input type="checkbox"/> Email to recipient	Name: _____ DOB: _____ Relation: _____

I am requesting to release the following specific documents: (check the documents to be released)

<input type="checkbox"/> Office notes	<input type="checkbox"/> Radiology reports	<input type="checkbox"/> Lab reports	<input type="checkbox"/> Hospital notes
<input type="checkbox"/> Operative reports	<input type="checkbox"/> Pathology reports	<input type="checkbox"/> Other:	
<input type="checkbox"/> All of the above	<input type="checkbox"/> Treatment dates/time range of checked item(s):		

I do not authorize the release of sensitive information pertaining to the following (please initial next to the item):

___ Mental health	___ Drugs or alcohol abuse	___ Genetic testing	___ HIV/AIDS/other infectious disease
___ Not applicable: none of the above apply			

Authorization to Release Medical Record (page 2 of 2)

Please initial each item below:

_____ I authorize the above person/organization and/or members of their staff to furnish the above information as directed in this authorization.

_____ I agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested.

_____ I understand that this authorization will expire on (insert date or event): _____.
If I fail to specify an expiration date, event or condition, this authorization will expire 12 months from the date on which it was signed.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure healthcare treatment. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

Signature of Patient: _____ Date: _____

If patient unable to sign, an authorized representative may sign below on behalf of the patient:

Legal Representative Printed Name

Legal Representative Signature

Date

Relationship to Patient

Reason patient unable to sign