

Authorization for Release of Protected Health Information

Patient Name: _____
Birth Date: _____ Social Security #: _____

I understand that by completing the box(es) below, if my Protected Health Information contains information related to the history, diagnosis and/or treatment of any of the listed situations, that my signing this document authorizes The Family Practice Center to release that information. I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege. Checking either the DNA or the Genetic information box indicates that I believe my records may contain DNA test results or other genetic information is specially protected by New Jersey Law, and I will be contacted for separate specific consent prior to release of this information.

I authorize the Family Practice Center to disclose my protected health information to the following extent:

(There may be a charge for providing copies)

	Medical Record	Billing Record
Specific Treatment Dates (Indicate to/from date in box to right)		
Specific Practice/Physician (Indicate name in box to the right)		
Specific Medical Forms (Indicate form in box to the right or attach a copy of from to be completed and check box to right)		
Entire Content of Record (Please check box(es) to the right)		

If the record requested above contains any of the following information, you must check the boxes below to authorize release of the specific information. If you **do not** check the boxes below, any information related to the boxes below contained in the requested record will not be released.

- | | | |
|--|--|--|
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Mental Illnesses | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Communicable Diseases | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Test for Infection with HIV | <input type="checkbox"/> Genetic Information |
| <input type="checkbox"/> DNA Test Results _____ (specify name of test) | | |

Indicate the name and address where the requested records are to be sent:

Name: Family Medicine at Monument Square
317 George Street
New Brunswick, NJ 08901
Phone Number: (732) 235-8993

This consent may be revoked at any time by writing to the Family Practice Center, at 1 Penn Plaza New Brunswick, New Jersey 08901. If not previously revoked, this consent will terminate upon _____.

(Indicate date/expiration of event, i.e. upon mailing)

The Family Practice Center will not make decisions concerning treatment, payment, enrollment or eligibility for benefits based on signing, refusing to sign or revoking this authorization.

I acknowledge and understand that uses and disclosures of my protected health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by privacy and confidentiality laws.

Signature of Patient or Legal Representative: _____ Date: _____
Print Name: _____
Relationship to Patient: _____ (attach a copy of proof of legal relationship, if applicable)