Authorization for Release of Protected Health Information (PHI)

Your Doctors Care
71 Rt. 206
Hillsborough, NJ 08844
Ph: 908-685-1887
Fax: 908-685-0162

Last Name_____First Name_____Middle Initial_____

Date of Birth: Month_____Day_____Year____ Social Security # _____

Address _____ City_____

State _____ Zip Code _____ Phone Number _____

I hereby authorize disclosure of my protected health information as follows: (Check all that apply)

Complete Medical Record for all services

Records related only to the following date(s) of service _____

If psychiatric records, HIV/AIDS information, substance abuse information, tuberculosis information, genetic information and/or sexually transmitted disease information is including in these records, check in the appropriate box below in order to not include such records in this release. If this section is left blank, authorization to release psychiatric records, HIV/AIDS records and substance abuse records will be presumed to be accepted.

□ HIV/AIDS Related Information
□ Genetic Information
□ Drug and Alcohol Information
□ Mental Health and Psychotherapy Information
□ Sexually Transmitted Disease Information
□ Tuberculosis

The purpose of this release of information is for:

Transfer of Records to another provider

Other (Describe) _____

Release of Information is to:

Name _____

Organization/Entity _____

Address _____ City_____

State_____ Zip Code_____ Phone #_____

Notice to Receiving Entities: Protected Health Information Disclosure Statement

The information on the above patient has been disclosed to you from records protected by NJ State Statutes NJS 26:5C-7, 26:5C-8 and or federal confidentiality rules 42 CFR part 2. Receiving entities are prohibited from further disclosure without the written consent of the above named patient. A general authorization for release is not sufficient for this purpose.

Signature_____Date_____