

718 Teaneck Road Teaneck, NJ 07666

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

| I hereby authorize you to furnish to: | |
|--|--|
| ☐ Physician ☐ Insurance Co. ☐ Legal ☐ Hospital ☐ Other | Doctor's Appt. Date |
| Name: | Time AM / PM (when applicable) |
| Address: | |
| | Fax #: |
| information, access to, or photocopies of the medical records of: | MD // |
| Patient's Name: | |
| Address. | |
| The foregoing is subject to the limitations as listed below: 1. Nature of information to be released: | |
| ☐ history/physical exam ☐ operative reports ☐ laboratory reports ☐ nurses notes ☐ discharge summary ☐ pathology report(s) ☐ physical therapy notes ☐ Emergency Department records | □ consultative reports□ x-ray reports□ progress notes□ other: |
| 2. This authorization is confined to the following dates of treatment: | fromto |
| 3. Purpose of release: | (month/date/year) (month/date/year) |
| ordered, performed or reported, regardless of whether the results of stalso include information about behavioral or mental health services, dration and tuberculosis information. I approve of the release of such in HIV/AIDS Drug or Alcohol Mental Health The provession of the release of such in HIV/AIDS Drug or Alcohol Mental Health The provession of the release of such in HIV/AIDS Provession of the release of such in HIV/AIDS Mental Health Mental Health The provession of the release of such in HIV/AIDS Mental Health Mental Health The provession of the release of such in HIV/AIDS Mental Health Mental He | rug and alcohol information, genetic inform- formation by initialing: ealth Genetics r page fee. The State of New Jersey allows accordingly unless there is an emergency. |
| I understand that information used or disclosed pursuant to the author recipient and no longer be protected by the rule. | |
| I further direct that only information prior to the date of my signature be this authorization be granted the same authority as the original. | elow be honored, and that a photocopy of |
| I further hereby release Holy Name Medical Center and you personally that may arise from the release of such records as specified above, ar their confidentiality. | y from all legal responsibility and/or liability and I hereby waive all rights I have to preserve |
| I understand I have the right to revoke this authorization at any time. I must do so in writing and present my written revocation to the Health understand the revocation will not apply to information that has already ization. I understand the revocation will not apply to my insurance con with the right to contest a claim under my policy. Unless otherwise revyear's time. If I fail to specify an expiration date, event or condition, the | Information Management Department. In the property of the property of the second of the provides of the provid |
| Signature of Patient: Date | e: |
| If the patient is a minor or is otherwise unable to sign this Authorization | n, obtain the following signature: |
| Signature of Patient Representative: | |
| Description of Authority: | |

FORM:RI (S0171MR) LAST REVISED: 1/28/13 REVISED: 3/23/15