AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ TELEPHONE NO.:_____

I hereby authorize to disclose my health information to:

SAMUEL Z. BROWN, ESQ.
205 EAST KENNEDY BOULEVARD
LAKEWOOD, NJ 08701

The information to be disclosed to and used by the above is for the following purpose:
CONTINUING CARE_____ ATTORNEY/LEGAL_____ INSURANCE_____

The authorization is limited to the following dates of treatment: FROM_____ TO_____

Information is to be faxed to the receiver: Yes:_____ Fax #: _____ No:_____

Information to be disclosed:

FACE SHEET	_____	**DISCHARGE SUMMARY**	_____	**HISTORY & PHYSICAL EXAM**	_____
CONSULTATIONS	_____	**LABORATORY & X-RAYS**	_____	**OPERATIVE REPORTS & PATHOLOGY**	_____
PROGRESS NOTES		**DOCTOR'S ORDERS**	_____	**EMERGENCY ROOM REPORT**	_____
		_COMPLETE RECORD	_____	**ADMISSION ASSESSMENT**	_____
	_____	**MEDICATIONS**	_____	**ABSTRACT OR OTHER**_____	
NURSE'S NOTES	_____				
PSYCHOSOCIAL	_____				

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, AIDS, and HIV, SEXUALLY TRANSMITTED, TUBERCULOSIS AND other INFECTIOUS DISEASE information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to an other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the 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 Medical Record Department. I understand the revocation will not apply to the extent that has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date or concurrently with the following event or condition.:
_____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or enrollment or eligibility in benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules.

DATE:_____ **PATIENT SIGNATURE:_____**
WITNESS:_____ **LEGAL REPRESENTATIVE:_____**
WITNESS:_____

CIRCLE ONE: PARENT/LEGAL GUARDIAN
POA/HEALTH CARE PROXY
ATTACH THE DOCUMENT OF AUTHORITY

(For Office Use Only)

Date Information Released:_____ Signature:_____