Allergy Diagnostic & Treatment Center

Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: ____-____-____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize *Dr. David K. Brown* to release information from my medical record as indicated below to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	DATES:
❑ History and physical exam	_____
❑ Progress notes	_____
❑ Lab reports	_____
❑ X-ray reports	_____
❑ Other: _____	_____
_____	_____

I specifically authorize the release of information relating to:
❑ Substance abuse (including alcohol/drug abuse)
❑ Mental health (including psychotherapy notes)
❑ HIV related information (AIDS related testing)
X_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ❑ Changing primary care doctor ❑ Consultation/second opinion ❑ Continuing care
❑ Legal ❑ Changing allergy care doctor ❑ Insurance
❑ Other (please specify): _____

1. I understand that this authorization will expire on ____/____/_____ or 14 days after I have signed the form.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

4. I understand that if I am being requested to release this information by _____ (Print Name of Provider) for the purpose of:
   _____
   _____
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that _____ (Print Name of Provider) ❑ will/ ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

5. I understand that in compliance with New Jersey statute, I will pay a fee of $_____ ($1.00 per page or $100.00 for the whole record, whichever is less). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ ____/____/_____
SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____ BY: _____
IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____