2124 Route 35,
Holmdel,
NJ,
07733.

Tel: (732) 788-0349
Fax: (877) 211-6276
E-mail: info@gramercypaincenter.com
www.gramercypaincenter.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize you to furnish to: Physician Insurance Co. Legal Hospital Other

Name: ______________________________________

Address: ____________________________________ Phone #: ____________________

____ Fax #:_______________________

Information, access to, or photocopies of the medical records of:

Patient's Name: _________________________________ MR #:_______________________

Address: _____________________________________ Birth Date: ___________________

____ Phone #:____________________

The forgoing is subject to the limitations as listed below:

1. Nature of information to be released:

History/physical exam	Discharge summary	Consultative reports
Operative reports	Pathology reports	X-ray reports
Laboratory reports	Physical therapy notes	Progress notes
Nurse's notes	Emergency dept. records	other: ________________

2. This authorization is confined to the following dates of treatment: from_________ to_________
(Month /date/ year) (Month /date/ year)

3. Purpose of release: ____

I understand that a statement that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the rule.

I further direct that only information prior to the date of my signature below be honored, and that a photocopy of this authorization be granted the same authority as the original.

I further hereby release Gramercy Pain Center and you personally from all legal responsibility and/or liability that may arise from the release of such records as specified above, and I hereby waive all rights I have to preserve their confidentiality.

I understand 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 health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year's time. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

Signature: ___________________________ Date: _________________ ** Valid for 1 year

SPECIAL AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I understand that the specific type of information to be disclosed includes HIV, drugs, alcohol, or psychiatric symptoms or ailments, or any other infectious disease information and the purpose of need for this disclosure

I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon, and that this consent will remain in force for a responsible time in order to effectuate the purpose for which it is given.

> This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR-Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose.

____ ____________________________**Valid for 90 days
Signature of patient or person authorized by law to give consent Date

____ ______________________________**Valid for 90 days
Signature of witness Date