



PO Box 8519  
Red Bank, NJ 07701

**RECORDS RELEASE REQUEST**

Provider Office Name: \_\_\_\_\_

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone number: \_\_\_\_\_ Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Records requested from:

Doctor/faculty: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**I authorize the office/facility indicated about to release copies of my medical records to the office facility indicated below.**

**Send my records to:**

Doctor/faculty: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

I authorize the release of any and all of my medical records. These records may include records concerning psychiatric treatment, drug and alcohol abuse treatment, Human Immunodeficiency Virus (HIV) infection and AIDS. This includes any test results and treatments, as well as counseling records. If you do not wish this information to be released, please initial: Do NOT release \_\_\_\_\_.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy office. Unless otherwise revoked, this authorization will expire in six months or on the following date: \_\_\_\_\_.

\_\_\_\_\_

Signature of Patient or Authorized Representative

\_\_\_\_\_

Date