PO Box 8519
Red Bank, NJ 07701

RECORDS RELEASE REQUEST

Provider Office Name: _____

Patient's Name: _____

Patient DOB: _____ **Phone Number:** _____

Patient Address: _____

City/State/Zip: _____

RECORDS REQUESTED FROM:

Doctor/Facility Name: _____

Address: _____**City/State/Zip**: _____

Phone Number: _____ **Fax Number:** _____

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

SEND MY RECORDS TO:

Doctor/Facility Name: _____

Address: _____

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 to have 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 (6) months or on the following date: _____.

_____ _____

Signature of Patient or Authorized Representative Date