Toll Free: (888) 985 - 2727 · Fax: (609) 567 - 8832

Authorization for Release of Patient Information

Patient Name: ______________________________ DOB: __________________

Address: ____

I, ____________________, the undersigned, authorize the release of or request access to the information specified below from the records of the above-named patient. A photocopy of this authorization shall have the same forgo and effect as the original copy.

Patient Information is needed for:

☐ Continued Medical Care ☐ Military ☐ Legal Purposes
☐ Insurance ☐ Personal Use ☐ Other: __________________
☐ School ☐ Social Security/Disability ____________________________

Patient Information is to be Released From:
Relievus
813 East Gate Dr.
Suite B
Mount Laurel, NJ 08054

Released To:
____
____
____
____

Information to be released or accessed:

☐ Complete Medical Records ☐ History & Physical ☐ Labs/X-Rays/Ultrasounds
☐ Complete Billing Records ☐ Progress Notes ☐ Other: __________________
☐ Demographic Information ☐ Operative Reports ____________________________

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to; History, Diagnosis, and/or Treatment of Drug or Alcohol Abuse, Mental Illness, or Communicable Disease, Including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on me signing this authorization, except in certain circumstances such as for participation in research programs or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged retrieval or processing fees for copies of my records according to the New Jersey Medical Board.

______________________________ ______________________________ ______________
Patient/Legal Representative Name Patient/Legal Representative Signature Date