Barnabas Health Medical Group | RWJBarnabas HEALTH
United Medical

612 RUTHERFORD AVE.
LYNDHURST, NJ 07071
TEL:(201)460-0063 FAX:(201)460-1684

988 BROADWAY, SUITE 201
BAYONNE, NJ 07002
TEL:(201)339-6111 FAX:(201)339-6333

533 LEXINGTON AVE.
CLIFTON, NJ 07011
TEL:(973)546-6844 FAX:(973)546-7707

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name : _____ **Birth Date**: _____

I request and authorize _____ to release healthcare information of the patient named above to:

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LYNDHURST, NJ 07071
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This request and authorization applies to:

__ Immunization records only

__ All healthcare information

__ Records from ___/___/___ to ___/___/___ (dates)

__ Records that contain the following specified information:

_____

__ Other: _____

If the requested medical records contain any information pertaining to HIV-related information, drug, alcohol or mental health treatment, <u>YOU MUST SPECIFICALLY CONSENT TO THE RELEASE OF SUCH INFORMATION BY INITIALING ONE OR BOTH OF THE FOLLOWING:</u>

__ I authorize the release of any HIV-related information that may be in my medical record only to the designated person(s)/clinic(s) listed above

__ I authorize the release of any records regarding drug, alcohol, or mental health treatment to only the designated person(s)/clinic(s) listed above

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization I must do so in writing and present my written revocation to United Medical PC. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 6 months from date of signature. A copy of this form is available to me upon my request. *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

_____ _____

Patient's Signature Date