New Jersey Spine Center
40 Main Street
Chatham, New Jersey 07928

Phone: (973) 635-0800 Fax#: (973) 635-3137

Email: medicalrecords@njspinecenter.com

Authorization to Release Protected Health Information Pursuant to Patient Request

INSTRUCTION: When form is complete, save the document to your computer, open your email and forward it as an attachment to **appointments@njspinecenter.com** or *fax it to* ***973-635-3137***.

____
Patient's Full Name

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

NJSC is authorized to release my entire medical record or, if the following section is completed, only such portion of my medical records as are specifically described in the following space: ____

____

1. NJSC may send my protected health information to the following designated below:

   ____ Initial __________

2. NJSC may receive my protected health information from the following designated below:

   ____ Initial __________

   Name

   Address | Phone#:

   City, State Zip code | Fax#:

   I understand that the medical records released may contain information pertaining to the following:

Drug and alcohol abuse	______	Routine consultations/examinations	______
Information concerning HIV	______	Results of diagnostic testing/lab results	______
Mental health information	______	History and physical	______
Treatment recommendations	______	Sexually transmitted diseases	______

I may limit this authorization by crossing out and initialing those items I do not want released.

3. I understand that the information being used or disclosed, New Jersey Spine Center cannot be held responsible for any breaches of protected health information by the recipient of the medical records.
4. I may revoke this authorization by notifying New Jersey Spine Center in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature (Patient or Custodial Guardian) | **Date**

Print Name | **Date**