REQUEST FOR RELEASE OF PATIENT RECORDS

RECORDS RELEASED FROM:

_____

_____

_____

I HEREBY AUTHORIZE YOU TO RELEASE RECORDS TO:

Primary Care Associates of NJ, LLC
329 Main Road
Montville, NJ 07045-9730
Phone: (973)334-9404

Date:_____

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of all healthcare information whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This will include all health care information in your possession, whether generated by your practice or any other source. Please include all medical records.

This release is subject to revocation at any time. The revocation is effective from the time it is communicated to the healthcare provider. If not revoked, it will terminate in accordance with HIPAA Public Law 104-191.

Patient's Name: _____
DOB: _____
Address: _____

Patient Signature: _____

Relationship if other than patient: _____

Date: _____

Witness: _____

PLEASE SEND RECORDS ASAP OR FAX TO (973)334-7615
We thank you in advance for your help and cooperation in this matter.