Annandale Family Practice, LLC

56 Payne Road, Suite 21 Lebanon, NJ 08833
Phone: (908)238-0100 Fax: (908)238-0951

Authorization for Disclosure of Protected Health Information

I, _____hereby authorize _____to disclose information from the records of _____ _____
Patient Name Date of Birth

The information is to be:

Released from: **Annandale Family Practice** To: _____ _____ _____	OR	Released to : **Annandale Family Practice** From: _____ _____ _____

Purpose for request:
____ for personal use only
____ relocation out of area
____ insurance change related
___transferring care to another local practice
___ other_____

The following information is to be released: (please check one)

_____**Entire Medical Record**. Records specifically protected under State and Federal Confidentiality Statutes. I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse , AIDS/HIV related, genetic, venereal disease, or tuberculosis information, which are protected under State and Federal law prohibits and further disclosure without written consent of the persons to whom it pertains or otherwise protected by law.

____**Only specific portions of the medical record**. Itemize portions of record and time period of records to be released and indicate specific records that may not be released_____
_____

Having read the above information , I release Annandale Family Practice, LLC, its employees, staff, and agents from all legal responsibility or liability that may arise from the disclosure of information set forth above relating to my protected information.

I understand that this authorization will remain in effect for 180 days or until I provide a written notice of revocation to Annandale Family Practice, LLC at the address listed above. The revocation will be effective immediately upon Annandale Family Practice's receipt of the written notice. I understand that revocation may not be made if the action has already been acted upon based on prior authorization.

_____ _____
Date Patient's Signature

_____ _____
Date Witness's Signature