Consent for Release of Medical Records

(PATIENT RECORD RELEASE TO ANOTHER PROVIDER)

Patient Name: _____ Date of Birth:_____
Address: _____ Phone Number: _____

I hereby authorize Hunterdon Digestive Health Specialists to release information from my medical records as indicated below to:

Name: _____ Phone Number: _____
Address: _____Fax Number: _____
Covering periods of health care from (date): _____ To (date):_____

Information to be released:

- Office Visit Notes
- Procedure Reports
- Pathology (Biopsy)
- Laboratory Tests (Blood work, stool samples)
- Radiology Tests (CT scan, MRI, US)
- Other (Please Specify) _____
- **Complete Health Records** (There is a $1.00 per page fee/ $10 minimum)

I understand that this will include information relating to (check if applicable):

- Acquired Immunodeficiency Syndrome (AIDS)
- Human Immunodeficiency Virus (HIV)
- Behavioral Health Service/Psychiatric Care
- Treatment for alcohol/and or drug use

Purpose of Disclosure:

- Changing of Physicians
- Continuing Care
- School
- Workers Compensation
- Consult/Second opinion
- Legal
- Insurance
- **Other** (please specify):_____

I understand that this authorization maybe revoked in writing at any time except to the extent that the action has taken in reliance on this authorization unless otherwise revoked. This authorization will expire in **90 days** from the date signed.

The facility, its employees and Physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Patient Signature: _____ Date: _____

Or Legal Representative: _____ Date: _____

Hunterdon Digestive Health Specialists

Phone: (908)-788-8200 Fax: (908)-788-8207

*There is no charge for records being forwarded to another facility for ongoing care or follow up treatments.