AUTHORIZATION FOR RELEASE AND DISCLOSE OF PATIENT INFORMATION

Patient Name: ____ Date of Birth: _____________________

Address: ____ Telephone: ______________________

THIS WILL AUTHORIZE NORTH JERSEY NEPHROLOGY, PA TO BOTH RELEASE AND OBTAIN FROM:

____

Name of Clinic/Provider

____

Address (Street/City/State/Zip)

____

Phone/Fax

THE FOLLOWING INFORMATION:
(Please check all that apply)

Medical Records _____ / Labs/ Radiology _____ / Progress Notes _____

I am requesting this information be released for the following purpose:

___ Coordination of Care ___ Insurance ___ Legal ___ Personal ___ Other: _______________

Information will be faxed unless otherwise indicated here: ____

- Please indicate any restrictions. (Specify) ____
- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form.
- I understand that the revocation will not apply to the information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time if specified here: __________ The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand that once the information is released pursuant to this authorization, North Jersey Nephrology, PA cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.

____ ____________________________________

Patient Signature Date