

SUSSEX COUNTY MEDICAL ASSOCIATES
123 Newton-Sparta Rd., Newton, NJ 07860
Phone 973-579-6300 Fax 973-579-1524
Authorization for Use and Disclosure of Health Information
RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

By signing this form, I hereby authorize:

(Name & Address of Person/Organization in Possession of my Information)

To disclose the health information described below to:

(Name & Address of Person/Organization to Receive my Information)

Check all that apply:

- All Health Information
- Health Information for the date(s) _____
- Health Information for the following treatment/condition:

- Other specific description: _____

Reason for this Authorization:

- Moving ___ I will not return to the area. ___ I will be returning to the area.
- Other (specify) _____

This Authorization expires on _____
(date or event, can state "none")

I understand that I may refuse to sign this Authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an Authorization if to do so would be prohibited by federal or state law. I understand an Authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an Authorization, those services may be denied.

I may revoke this Authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Practice Manager at the health care provider listed above.

Patient/Legally Authorized Representative

Date

Printed Name

Relationship to Patient