

**New Jersey Pain Care Center, PC**

44 Route 23 North, Suite 15B  
Riverdale, NJ 07457  
Phone: (973) 400 -1716 Fax: (973) 400-1631

**Authorization for Release and Disclosure of Protected Health Information**

**In accordance with state law and regulatory agency requirements, the health record is the property of New Jersey Pain Care Center, PC**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Alternate Contact Number: \_\_\_\_\_

**Information May Be Released To:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

**Please release the following information:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Problem List            | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Outside Records |
| <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> X-ray Films   | <input type="checkbox"/> Drug/Alcohol  | <input type="checkbox"/> Immunizations   |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> EKG Reports   | <input type="checkbox"/> Lab Reports   | <input type="checkbox"/> HIV/AIDS Test   |
| <input type="checkbox"/> Medications             | Other Reports (Specify) _____          |  |  |

**This information is necessary for the following purpose:**

- |  |                                       |   |                                    |
|--|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Continued Patient Care  | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> (Other (Specify) _____) |                                       |   |                                    |

- I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol/drug abuse.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insure
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions, I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Health Information Management Manager at (973) 400-1716

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

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