THE SPINE & HEALTH CENTER OF NEW JERSEY

RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ _____
Please Print (Last Name) (First Name)

DATE OF BIRTH: _____ SOCIAL SECURITY: _____-_____-_____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:
3. The Type of information to be used or disclosed is as follows: (included dates where appropriate)

☐ **Emergency Records** **Date:** _____

☐ **Operative Reports** **Date:** _____

☐ **Admission** **Date:** _____

☐ **X-ray & Imaging Reports** **Date:** _____

☐ **Consultation Reports** **(Doctor's name):** _____

☐ **Most Recent Discharge Summary**

☐ **Laboratory Results**

☐ **Entire Records**

☐ **Other** _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired Immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization.

THE SPINE AND HEALTH CENTER OF MONTVALE **2 S. KINDERKAMACK ROAD MONTVALE, NJ 07645**
(Name) (Address)

For the purpose of: Investigating and pursuing a bodily injury case on my behalf.

1. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524, I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information).

Signature of Patient X_____ _____
(Please sign here) (Date)

Signature of Witness X _____ _____
(Please sign here) (Date)

Any person who knowingly files a statement of claim containing any False or Misleading Information is subject to criminal and civil penalties