

PSYCHOLOGICAL & BEHAVIORAL HEALTH SERVICES

595 Shrewsbury Avenue, Ste 205, Shrewsbury NJ 07702

<https://www.psychhealthnj.com>

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SECTION I – Patient Information

Patient Name	Date of Birth <small>MM DD YYYY</small>	Telephone Number
Street Address	City, State,	Zip

SECTION II – Health Information

I hereby authorize and request _____ [PROVIDER'S NAME] and staff at Psychological & Behavioral Health Services to release or receive confidential information including my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions, including records related to:

Initial each to approve release: ___ Mental Health ___ Alcohol/Drug Abuse Treatment ___ Genetic Information
___ Communicable Diseases including but not limited to HIV/AIDS

SECTION III – Recipient Information

Individual/Organization Name	Telephone Number	
Street Address	City, State, Zip	Fax Number

_____ (please initial) I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

SECTION IV – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request':

SECTION V – Revocation

I understand that I am permitted to revoke this authorization to share my health data at any by notifying, in writing, the [CENTER NAME]. I further understand that:

- If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in Section III.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

SECTION VI – Signature

By signing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Medical Information request.

Signature of Patient or Legal Representative

_____/_____/_____
Date

Printed Name of Patient or Legal Representative

Relationship to Patient

Patient Representative's Authority to Act for Patient (attach supporting documentation)