Women's Health Specialists of CentraState
(PATIENT RECORDS TRANSFERRING INTO PRACTICE)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named healthcare provider to release the information or records specified to the provider below upon request in person or by mail to the address specified at the time of the request. **PLEASE MAIL ANY RECORDS OVER 20 PAGES**

Provider: **Women's Health Specialists of CentraState** **479 Rte 520** **Suite A202** **Marlboro, NJ 07746** **Ph: 732-837-1130 FAX: 732-834-0142**	Patient: SS#: DOB:

FROM:(**SPECIALIST NAME)**_____

_____

RECORDS AUTHORIZED TO BE RELEASED:

___Admission history and physical
___Discharge summary
___Complete hospital chart
___Office notes
___Outpatient records
___Psychiatric and other mental health records
___Lab reports
___Radiological images
___Consultation notes or reports
___Complaints or grievances filed, with Responses or dispositions
___Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
___Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me. (These records should be redacted to protect information pertaining to other patients)
___Other (specify):_____

Extent or nature of records to be released:_____
(example, specific hospitalization or visit)

This information will be used for the purpose of:

___Investigating an allegation of abuse
___Providing advocacy services
___Other activities at the request of the individual
___Continuty of care(**changing providers)**
___Verifying my eligibility for services offered by the _____
___Legal representation

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the healthcare provider or to the ,
But that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____
Patient/Represenative Signature Date

_____
Name of Representative (print)

_____
Relationship to Patient

Revised: 5.8.19