Medical Information Release Form

(HIPAA Release Form)

Name:_____ **Date of Birth:**____/____/____

Release of Information

[ ] I authorize Princeton Wound Care Center the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____between (*time*)_____

Signed:_____Date:____/____/_____

Witness:_____Date:____/____/_____

Please note: Copies of medical records will be billed at the rate set forth by NJ DOH (8:43A-13.5 b 1).
The fee for copying records shall not exceed $1.00 per page or $100.00 per record for the first 100 pages. For records which contain more than 100 pages, a copying fee of no more than $0.25 per page may be charged for pages in excess of the first 100 pages, up to a maximum of $200.00 for the entire record. If the record is to be mailed, a postage charge of actual costs for mailing, not to exceed $5.00 will be charged.