Garden State Pain Control Center

Interventional Pain Medicine – Orthopaedic Surgery – Sports Medicine
Regenerative Medicine - Vein Therapy - Electrodiagnostic Testing
Phone: 973-777-5444 Fax: 973-777-0304

Pain Medicine

Neil Sinha, MD

Dev Sinha, MD

Saurabh K. Dang, MD

Dipan G. Patel, MD

Jahnna H. Levy, DO

Andrew So, MD

Tyler Dugan, PA-C

Orthopaedic Surgery

Deepan N. Patel, MD

Jake Pawela, PA-C

Locations

1117 Route 46 East
Suite 301
Clifton, NJ 07013

25 S. Main St
Suite 12
Edison, NJ 08837

631 Grand St
Suite 2-100
Jersey City, NJ 07304

226 Middle Rd
Suite #4
Hazlet, NJ 07730

RELEASE OF INFORMATION

I,_____, authorize and release the disclosure of all my health information By: GARDEN STATE PAIN CONTROL

To: □Primary Care Physician □Attorney/Adjuster □Referring Doctor □Physical Therapist □Other:_____

For: □Continuing Care, □Personal, □Transfer of Care, □Disability Determination, □Legal, □Worker Comp, □Insurance, □Other:_____

List whom you would like to SHARE your MEDICAL HEALTH Information with:
NAME:_____
RELATIONSHIP TO PATIENT:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
PHONE NUMBER:_____

I hereby request a copy of the following patient's medical record:

FULL NAME OF PATIENT:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
PHONE NUMBER:_____DATE OF BIRTH_____
INFORMATION TO BE RELEASED:

This authorization includes release of information concerning treatment of psychiatric/ psychological conditions, drug and/or alcohol related conditions , and HIV or AIDS related conditions, X-Ray/ medical imaging reports, emergency department records, operative reports, history and physical, laboratory results, discharge summary and entire record to Garden State Pain Control Center.

I understand that I may revoke this authorization at any time except to the extent that information has already been released in response to this authorization.

I understand that I may revoke this authorization by making the request in writing and giving it to an office staff member.

I understand that information disclosed in response to this authorization may be disclosed by the recipient and therefore is no longer protected.

I understand that my treatment may not be conditioned on the signing of this authorization.

Please note that once the records leave the premises of Garden State Pain Control via mail or email GSP is no longer liable for the requested medical records

SIGNATURE:_____DATE:_____
RELATIONSHIP IF OTHER THAN PATIENT:_____
EXPIRATION DATE OR EVENT:_____