# New Jersey Advanced Pain Management Center

Patient Name:_____ Date of Birth:_____
Address:_____ City:_____ State:____ Zip:_____
Telephone Number:_____ Social Security Number:_____

***I authorize release of my health care information concerning (please check off at least one of the following)**

1.___ All health care records 2.___ Treatment of (please identify condition):

3.___ Treatment received on the following dates: _____ to

4.___ Other (please describe):

***Sensitive records require specific patient authorization. Please initial the appropriate records requested.**

I authorize the information listed below to be used, disclosed or received:
___ Mental health __ STD's including HIV/AIDS __ Drug/alcohol abuse/treatment.

*** Request:**
I authorize _____ to release my private health information as identified above to:

Ajay Kumar, MD
905 Pennsylvania Ave Ste B
Matamoras, PA 18336
(973)917-3800 (P) (973)206-2236 (F)

*** Release:**
I authorize Ajay Kumar, MD to release my personal health care information to:

Name:_____ Phone/Fax Number: _____
Address: _____

* I understand the following:
A. I may revoke this authorization at any time by providing written notice to the practice.
B. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance overage.
C. The practice will not condition treatment or payment based on my signing this authorization.
D. I am signing authorization freely and under no pressure from any individual to do so.
E. The information disclosed in this had an opportunity to review this authorization and understand the intent and use.
F. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
G. This authorization may include disclosure of information relating to ALCOHOL and DRUG abuse, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate box above.

Patient Signature: _____ Date: _____