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HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

FULL NAME OF PATIENT:____

ADDRESS:____________________________________APT:__________________

CITY:______________________STATE:________________ZIPCODE:__________

DATE OF BIRTH:________________________SSN#:_______________________

INFORMATION TO BE RELEASED:
THIS AUTHORIZATION INCLUDES RELEASE OF INFORMATION CONCERNING TREATMENT OF PSYCHIATRIC/ PSYCHOLOGICAL CONDITIONS, DRU AND/OR ALCOHOL RELATED CONDITIONS, AND HIV OR AIDS RELATED CONDITIONS.
DATE OF SERVICE OR DATE RANGES REQUESTED:______________________________________

- ○ DISCHARGE SUMMARY
- ○ HISTORY & PHYSICAL
- ○ FACE SHEET
- ○ EMERGENCY DEPARTMENT RECORD
- ○ OPERATIVE REPORTS
- ○ PATHOLOGY REPORTS
- ○ LABORATORY REPORTS
- ○ IMMUNIZATION/SHOT RECORDS
- ○ OUTPATIENT RECORDS
- ○ ITEMIZED BILL
- ○ NEUROPSYCHOLOGICAL REPORTS
- ○ PSYCHOLOGICAL REPORTS
- ○ X-RAY/MEDICAL IMAGING REPORT
- ○ ENTIRE MEDICAL RECORD
- ○ OTHER:____

THE ABOVE INFORMATION IS TO BE RELEASED TO:
GARDEN STATE PAIN CONTROL CENTER, PA
1117 ROUTE 46 EAST, SUITE 301
CLIFTON, NJ 07013

- ○ CONTINUED MEDICAL CARE

- **PERSONAL INTEREST**
- **LEGAL CLAIM PROCESSING**
- **INSURNACE CLAIM PROCESSING**
- **EXTERNAL QUIALITY/UTILIZATION REVIEW**
- **OTHER (SPECIFY):____**

PATIENT SIGNATURE:____
DATE:____________________________________
PATIENT GUARDIAN/AUTHORIZED REPRESENTATIVE:___________________________________DATE:________________