

Patient Care of New Jersey

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AUTHORIZATION TO RELEASE INFORMATION

I, _____,
(name) (date of birth) _____ hereby authorize
release of my medical (social security number) records from:

Physician or Medical Facility _____

Address _____

Phone _____ Fax _____

to the attention of _____

Description of the information to be released: (check all that apply)

___ Labs ___ Discharge Summary ___ Medical Record 1 year

___ Other: _____

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations
- I understand that I may revoke or terminate this authorization by submitting a written revocation to Patient Care Center of New Jersey.

Patient (or patient representative) Signature: _____ Date: _____

Relationship of patient representative to patient: _____

Witness Signature: _____