GARDEN STATE PHYSICIANS, P.C.

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Authorization for Disclosure of Protected Health Information

I, _____ hereby authorize _____

To disclose information from the records of _____ _____
Patient's Name Date of Birth

The information is to be:

_____ Released to: GARDEN STATE PHYSICIANS or _____ Released from: GARDEN STATE PHYSICIANS purpose for request: _____ transferring care _____ relocation out of area _____ insurance changes _____ hospital care or specialist records _____ other

The following information is to be released: (Please check one)

_____ Entire Medical Record. Records specifically protected under State and Federal Confidentiality Statues. I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse, AIDS/HIV related, genetic, venereal disease or tuberculosis information, which are protected under State and federal law and prohibits any further disclosure without consent of the person to whom it pertains to or otherwise provided by law.

_____ Only specific portions of the medical record. Itemized portions of record, and time period of records to be released and indicate any specific records that may not be released. _____

_____

Having read the above information, I releases Garden State Physicians, its employees, staff and agents from all legal responsibility or liability that may arise from the disclosure of information set forth above relating to my protected Health Information.

I understand that this authorization will remain in effect for 180 days or until I provide a written notice of revocation to Garden State Physicians Privacy Office at one of the addressees listed above. The revocation will be effective immediately upon Garden State Physicians receipt of written notice. I understand that revocation may not be made if those action has already been acted upon based on prior authorization.

_____ _____
Date of Signature *Patient's Signature*

_____ _____
Witness *Signature of Responsible Party*

If patient is unable to sign, complete the following:

_____ Patient is a minor _____ years of age

_____ Patient is unable to sign because _____