Authorization for Release of Medical Records

HARMONY ACUPUNCTURE AND WELLNESS, LLC
Ph: 908.272.8288

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)				
Patient Name		Date of Birth		Social Security Number
Address	City	State	Zip	Phone

RELEASE FROM: (Name of physician or facility releasing information)				
I authorize release of my medical records from:				
Physician/Facility				Fax
Address	City	State	Zip	Phone

RELEASE TO: (Name of physician or facility receiving information)				
Please send my medical records to:				
Physician/Facility **HARMONY ACUPUNCTURE AND WELLNESS, LLC**				Fax **908.272.8288**
Address **45 SOUTH AVENUE WEST**	City **CRANFORD**	State **NJ**	Zip **07016**	Phone **908.272.8288**

RELEASE INFORMATION

Reason: [ ] Change of insurance [ ] Transfer of care [ ] Personal file
[ ] Moving out of area [ ] Special consultation [ ] Legal [ ] Doctor's Request

Please release the following (check all that apply)

RECENT H&P		LAST THREE VISITS	
LAB REPORTS		X-RAY REPORTS	
HOSPITAL REPORTS		OTHER:	

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

	YES	NO	INITIALS
I authorize the release of HIV/HTLV/AIDS test results.			
I understand that I may be charged for copies provided.			

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.