FISCHER FAMILY MEDICINE, P.A.
1191 Fischer Blvd
Toms River, NJ 08753
732-506-7888/732-506-7766 (fax)

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

PATIENT NAME:_____ DOB:_______________

PHONE #:_____SS#:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

INFORMATION TO BE DISCLOSED:

PLEASE SPECIFY WHICH RECORDS & DATES TO BE RELEASED:

_____

REASON FOR REQUEST: *Personal Use___ Legal___ Specialist___ Change PCP___*

RELEASE RECORDS FROM:

NAME OF PHYSICIAN:_____

ADDRESS:_____

PHONE#:_____FAX#:_____

_____ I WILL PICK UP RECORDS FROM OFFICE

_____ PLEASE MAIL RECORDS TO:

NAME:_____

ADDRESS:_____

PHONE#:_____FAX#:_____

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 coverage. C) The practice will not condition treatment or payment based on my signing this authorization. D) I am signing this authorization freely and under no pressure from any individual to do so. E) The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by the federal law. F) I acknowledge that I have had the opportunity to review this authorization and understand the intent and use. G) This authorization will include disclosure of information relating to ALCOHOL and DRUG ABUSE and CONFIDENTIAL HIV RELATED INFORMATION unless specified NOT to. H) If I am authorizing the release of HIV related, alcohol, or drug information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization.

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____