Bucks Mercer Neurology
396 Whitehorse Ave.
1st Floor
Hamilton, NJ 08610
Phone: 609-585-0118
Fax: 609-585-0244

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patients Address: _____

City: _____ State: _____ Zip Code: _____

I request and authorize **Bucks Mercer Neurology** to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please send this via ☐ Mail ☐ Fax (Charts larger than 15 pages cannot be faxed) or ☐ Pick up

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I release **Bucks Mercer Neurology**, from any laws related to disclosure of confidential or privileged information.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.