AUTHORIZATION FOR THE RELEASE OF MEDICAL and PSYCHOLOGICAL INFORMATION
Please Fill out and fax to 609-645-9780

Patient's Name: ____ Date of birth: __________________

Address: _______________________________________ City: ___________________________ State: _____

I hereby authorize: Pain Specialists / Seashore Ambulatory Surgery Center
1907 New Road
Northfield, NJ 08225
P: 609-645-8884
F: 609-645-9780

To release any and all information in my medical records to:

Name: ____

Address: ___________________________________ City: ______________________________ State: ______

Please specify dates if necessary: ____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing to this office. I understand that this revocation does not apply to information that has already been released in response to this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency (AIDS) or human Immunodeficiency (HIV), sexually transmitted diseases, tuberculosis information or genetics.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the office manager at this facility.

I now certify by my signature below that I have read and fully understand every part of the form.

Sign: ____Date: _____________________

If patient is unable to sign, state reason why and sign below:

____

Empowered representative's signature and relationship:

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