

**AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE**

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize: \_\_\_\_\_  
Name of physician's office/medical practice disclosing information

**REQUESTOR/RECIPIENT INFORMATION**

Please disclose the following protected health information to: Gill & Chamas

Street Address: 655 Florida Grove Road P.O. Box: 760

City: Woodbridge State: NJ Zip Code: 07095

Please indicate the information or types of information to be disclosed: All information, records, x-rays, reports or copies thereof relating to my examination, consultation, confinement or treatment and to permit them to inspect and make copies or abstracts thereof. You are also authorized to send any psychiatric, drug and/or alcoholic information if applicable.

Specify dates (or date ranges) if applicable: \_\_\_\_\_

This request is for the purpose of: Litigation

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization will expire in six months or on the following date: \_\_\_\_\_

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 privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

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

**IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE \_\_\_\_\_.**

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Representative's Authority  
(witness signature required)

\_\_\_\_\_  
Signature of Witness