Premier Health Associates
123 Newton Sparta Road
Newton, NJ 07860

Authorization for Use and Disclosure of Health Information

Release of Medical Records

Patient Name: ______________________________ DOB: ______________

By Signing this form I hereby authorize: ______________________________
(Name & Address of Person/Organization in possession of my health information)

To disclose OR obtain the health information described below to: ______________________________
(Name & Address of Person/Organization in possession of my health information)

Physician(s) you're requesting records from ______________________________

Reason for request ______________________________

Check all that apply:

- ☐ All Health Information
- ☐ Health Information for the date(s) ______________________________
- ☐ Health Information for the following treatment/condition: ______________________________
- ☐ Other specific description: ______________________________

Reason for this Authorization:

- ☐ Moving _____ I will not return to the area. _____ I will be returning to the area.
- ☐ New patients requesting consultation/treatment.
- ☐ Continuity of Care - Physician to Physician
- ☐ Other (specify) ______________________________

This Authorization expires on ______________________________
(date or event, can state "none")

I understand that I may refuse to sign this Authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an Authorization if to do so would be prohibited by federal or state law. I understand an Authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an Authorization those services may be denied.

I may revoke this Authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Practice Manager at the healthcare provider listed above.

______________________________ ______________________________
Patient/Legally Authorized Representative *Date*

______________________________ ______________________________
Printed Name *Relationship to Patient*