NEUROLOGY GROUP of BERGEN COUNTY

www.neurobergen.com

Medical Record Release Authorization

Patient Name _____ Maiden Name _____ SS # _____

Date of Birth _____ Home Phone _____ Cell/Work _____

Address _____ City/State/Zip _____

Email Address: _____

A) I hereby authorize records FROM:

Name _____

Address_____

City/State/Zip _____

Phone#_____ Fax #_____

B) To be released TO:

Name _____

Address _____

City/state/Zip _____

Phone #_____ Fax # _____

C) For the purpose of:

____ Continuity of Care/Transfer of Care

____ Self/Personal Copy

____ Insurance

____ Work Comp

_____ Litigation

_____Disability

____ Other

Date Range _____ to _____

- ❑ Physicians Office Notes
- ❑ Operative Procedure Reports
- ❑ Radiology/Xray /MRI reports
- ❑ Lab/pathology reports
- ❑ Genetic Testing
- ❑ Drug/Alcohol Treatment
- ❑ Mental Health Treatment

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date _____

Expiration date of authorization

***PLEASE READ** Fee information: **Neurology Group of Bergen County** contracts with an outside party to copy and provide all medical records requested form our office. We reserve the right to charge a Reasonable Fee schedule in the State of New Jersey. $1.00 per page up to 100 pages, plus postage will be invoiced to you from the outside party with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay the outside party for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy