advocare | Premier Ob/Gyn of South Jersey

Authorization For Release of Patient Records – Fax to 856-772-2301

Name: _____ Date: _____

Address: _____

Phone #:_____DOB: _____

I authorize **Advocare Premier OBGYN of South Jersey** to disclose to:

New Office: _____

Address: _____

Fax: _____

[ ] ALL medical records from Advocare Premier OBGYN of South Jersey

[ ] Medical records to the following extent: _____

_____

Reason for disclosure: _____

I understand that if my medical records contain information related to the history, diagnosis and/or treatment of any psychiatric problem, mental illness, drug abuse, alcoholism, sexually transmitted or communicable diseases, AIDS, or test for infection with human immunodeficiency virus (HIV), or tests for genetic diseases, including DNA tests, that my signing this document authorizes Advocare Premier OBGYN of South Jersey to release that information. I acknowledge and am aware that New Jersey has statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege, except as specified above.

This consent may be revoked at any time by writing to Advocare Premier OBGYN of South Jersey, except to the extent that records have already been released in reliance on this form. This consent otherwise will expire 90 days after the dated signature below.

I acknowledge and understand that uses and disclosure of my health information authorized by this document may be subject to re-disclosure by the recipient and may not be protected by privacy and confidentiality laws.

Signature of patient or guardian:_____Date:_____

Please return the completed form to our office. Note that there may be a charge for copies per state Medical Society guidelines. If so, a staff member will contact you to review any charges.

Eric B. Grossman, MD • Roberta G. Felsenstein, MD • Jessica Kraemer, CNM • Candice Disanti, CNM • Kathleen Lindemuth, WHNP

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