WATCHUNG
PEDIATRICS

76 Stirling Road
Suite 201
Warren, NJ 07059
908-755-KIDS (5437)
908-755-6905 (fax)

225 Millburn Avenue
Suite 301
Millburn, NJ 07041
973-376-PEDS (7337)
973-218-6647 (fax)

346 South Avenue
Suite 3
Fanwood, NJ 07023
908-889-TOTS (8687)
908-889-0047 (fax)

www.watchungpediatrics.com

Authorization to Release Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information may no longer be protected by federal privacy regulations and that it may be re- disclosed by the recipient.

Patient (s) Name(s) and Dates of Birth: _____

Organization Providing the Information: _____ Phone#: _____

Organization(s) or Person(s) Receiving the Information: (Circle One)

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Millburn, NJ 07041
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Fax: 973-218-6647

Specific Description of Information Disclosed: Complete Medical Records

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information purposes indicated below by initialing before each category:

Initials:____HIV/AIDS testing, test results; treatment and related information including high risk behavior documented:

Initials:____drug and/or alcohol diagnosis: treatment, test results, reports and referral information;

Initials:____mental health treatment information. test results and reports including psychological and psychological and psychiatric studies, reports, evaluations and referral information; and/or

Initials:____information regarding sexually transmitted diseases;

Initials:____genetic testing, test results, counseling reports, treatment, and referral information.

You must read and initial the following statements:

1. I understand this Authorization will expire one year from date below OR on __ / __ / __. This allows the disclosing office to forward any information received to my new provider without requiring a new authorization form to be completed. **Initials: ____**

2. I understand that I may revoke this Authorization at any time by notifying the disclosing office's Privacy Officer in writing, but if I do, it will not have any effect on any actions they took before they received the revocation. **Initials: ____**

_____ _____
Signature of Patient or Representative and Relationship Date

You may refuse to sign this authorization. We cannot condition treatment on your signing this Authorization