



WATCHUNG PEDIATRICS



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Suite 201
Warren, NJ 07059
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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 Medical Records

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: Watchung Pediatrics, 76 Stirling Rd, Ste 201, Warren, NJ 07059

Organization or Provider Receiving the Information: _____

Specific Description of Information Disclosed: Medical History Summary and Immunization Record (no cost)
Complete Medical Record (\$50 fee)
Other: _____

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 and 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.

Purpose of Discloser:

- New insurance
- Transfer to an adult physician
- Transfer to new Pediatrician (list name)
- Moving out of state (list state) _____
- Other (specify) _____

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:**

Charge:

As per NJ Statute, Watchung Pediatrics charges a medical record transfer fee of \$1 per page, with a maximum \$100, *per child*.

When records are copied, and mailed directly to a physician, the maximum charge is \$50 *per child*, payable at the time the request is submitted.

Patients may have a Medical Summary and immunization record *free of charge*.

Please allow 30 business days for your request to be processed.

Signature of Patient or Representative and Relationship
You may refuse to sign this authorization. We cannot condition treatment on your signing this Authorization.

Date
Rev02/2022 office/forms/chartforms