MOVSHOVICH PC
DIABETIC EYE CENTER OF NEW JERSEY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

1.) PATIENT INFORMATION :

_____ _____ _____
Name Date of Birth Home Phone #

_____ _____ _____ _____
Address City State Zip Code

2.) AUTHORIZES:

_____
Name of Medical Office

_____
Address of Medical Office

3.) TO DISCLOSE TO:

Send To: _____
Name of Recipient

_____ _____
Address Or Fax #

4.) DATE(S) OF INFORMATION TO BE DISCLOSED:

From _____(month/year) to _____(month/year)

If left blank, only information from the past two (2) years will be disclosed.

By signing below, you agree to the following:

1.) I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.

2.) I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.

3.) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of this form.

4.) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment

5.) I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted at the top of this form.

6.) I understand that a copy or Fax of this document is just as valid as the original document.

_____ _____ _____
Signature of Patient or Authorized Person Date Contact Telephone Number