GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZED FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ SS #: _____
First Name MI Last Name

Date of Birth: _____ Address: _____

Home Phone: _____

I authorize the disclosure/release of the following information: (check all that apply)

☐ All records

☐ Laboratory/Pathology/X-Ray records

☐ Other: _____

Please send the records listed above:

From: _____

Phone: _____

Fax: _____

To: Sahni Rhematology & Therapy

Phone: (732) 272 1456

Fax: (888) 481-1478

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature: _____ Date: _____

Printed Name: _____