

HUDSON COUNTY PRIMARY CARE

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MEDICAL RECORDS RELEASE FORM

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

I HEREBY AUTHORIZE THE BELOW LISTED ENTITY TO RELEASE MEDICAL INFORMATION TO
HUDSON COUNTY PRIMARY CARE, LLC:

NAME: _____

TEL: _____ FAX: _____

ADDRESS: _____

MEDICAL INFORMATION REQUESTED:

- ALL RECORDS
- SPECIFIC RECORDS FROM _____ TO _____
- PHYSICAL EXAMINATIONS
- LAB RESULTS
- RADIOLOGIC FILMS AND/OR REPORTS
- IMMUNIZATION RECORDS

SIGNATURE: _____ DATE: _____

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.