Integrated Pediatrics

666 Plainsboro Road, Suite 424
Plainsboro NJ 08536
609-750-7383
Fax-609-228-5279

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information.

Purpose: I authorize the release of my health information for the following specific purpose: _____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

- ❑ Only the following records or types of health information:
  _____.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

_____	_____	_____	_____
Patient name	DOB	Date	Signature of Patient or Guardian

_____	_____	_____	_____
Patient name	DOB	Date	Signature of Patient or Guardian

_____

[1]