AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (HIPAA)

I. Patient Information

Name:_____ Date of Birth:_____

Address:_____ Phone:_____

City/State:_____

II. Release Information

Information to be released to: **Kincaid Wolstein Vocational & Rehabilitation Services**
Dr. Dan Wolstein
One University Plaza – Suite 302, Hackensack, New Jersey
T. 201.343.0700 F. 201.343.0757

Information to be release:
☐ All medical records
☐ Medical records for the following dates:_____
☐ Medical records relating to the following treatment/condition: _____
_____
☒ Other (e.g. X-rays, bills): Dr. Wolstein Future Care Considerations

I understand that certain information cannot be released without specific authorization as required by law. By checking the boxes below I authorize you to release information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus) ☐ Sexually transmitted diseases ☐ Drug and/or alcohol use
☐ Psychiatric disorders/mental health ☐ Genetic testing

Reason for the release:
☐ Personal ☐ Doctor ☒ Attorney (Litigation) ☐ Insurance ☐ Education

III. Patient Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, eligibility or enrollment). I may revoke this authorization in writing at any time. If I do, it will not affect any actions already taken by Dr. Wolstein based upon this authorization. To revoke this authorization, I must write a letter to Dr. Wolstein. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal or state privacy laws and may be re-disclosed by the person or organization that receives the information. I release Dr. Wolstein, his employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

This authorization expires _____ - (if left unsigned, then ___ months from the date of this authorization).

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)