

# Patient Intake Information

*All fields on this page are required.*

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Street Address:

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City:

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State:

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ZIP Code:

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Type of Report Requested:

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☐ Vocational Evaluation

☐ Life Care Plan

☐ Forensic Economics

☐ Other / Not sure

If Other, please specify:

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## 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)