

Middlesex Medical Care

619 Union Avenue , Bldg 1, First Floor
Middlesex, NJ 08846

Telephone: 732.356.3212
Facsimile: 732.356.5002

Date: _____

Patient Name: _____

Patient Date of Birth: _____

I authorize disclosure of my protected health information only in the specific manner, for the named reason, and to the specific individual(s) named below.

Specific description of information to be used or disclosed:

Reason for request:

Transfer of records to Middlesex Medical Care

Specific individual(s) or entities that may receive disclosure of my protected health information:

Middlesex Medical Care
619 Union Avenue ~ Building 1, First Floor
Middlesex, NJ 08846

This authorization provides that:

I may revoke this authorization at any time, provided that revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of insurance coverage.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA privacy rules.

This practice will not condition treatment on my providing authorization for the requested use or disclosure.

I have the right to access my protected health information to be used or disclosed.

I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____
Patient Name

Relationship to patient if signed by a personal representative: _____