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Best Choice Obstetrics & Gynecology

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's Name _____ Date of Birth: _____

Home Address: _____ Phone #: _____

1. INFORMATION TO BE RELEASED: date(s) of service _____

   ☐ Entire Medical Record ☐ History and Physical ☐ Progress Notes

   ☐ Consultation reports ☐ Labs ☐ Billing Records

   ☐ Other (specify) _____

2. SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE:

   By signing my initials next to each specific category of highly confidential information, I am authorizing the Best Choice OB-GYN to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above.

   _____ HIV/AIDS Related Information _____ Sexually Transmitted Disease Information

   _____ Mental Health _____ Genetic Information

   _____ Drug and Alcohol Information _____ Tuberculosis Information

3. RELEASE INFORMATION TO: ☐ Myself (the patient or representative) ☐ To the organization below:

   _____ _____ _____
   Organization Individual Name Phone

   _____
   Street Address City State

   ☐ Please prepare for pick-up ☐ Please Mail

4. TERM/AUTHORIZATION: This signed authorization must have an expiration date.
   This Authorization will no longer be valid after: _____.

6. FEES: (apply to photocopies provided to patients and their legally authorized representatives only;
   Other fees may apply to other requestors):
   I understand that the Best Choice OB-GYN is permitted under state and federal laws to charge me for photocopies of my medical records and any applicable mailing/postage fees. I further understand that under New Jersey law, the fees are based on actual costs and may not exceed $1.00 per page or $100.00 per record (for the first 100 pages) and $0.25 per page thereafter up to a maximum of $200.00 per record. A search fee of no more than $10) per patient per request may also be charged. If applicable, a fee for a written summary in lieu of photocopies of the original records may be obtained for:
   $_____.

_____ _____ _____
Name (print) Signature Date