Please fill out the entire Form so that your Medical Record can be released:

* Name/Address/Date of Birth & Date of Request
* Email Form megoser@thestonecenter.org
* Mail Form: The Stone Center of NJ

830 Morris Turnpike, Suite 303

Short Hills, NJ 07078

* **Document must be notarized if form not completed in person at The Stone Center. Legal representative must provide proof of status and have signature notarized.**

**PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_**

1. I authorize the use or disclosure of the above named individual’s health information, as described below.
2. The Stone Center of New Jersey, LLC is authorized to make the disclosure set forth below.
3. The information may be disclosed to, and used by, the following individuals or organizations:

Name(s): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For the following purpose(s): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose(s) and may include the following items (unless crossed out by me).
* Information regarding Human Immunodeficiency Virus (HIV), including laboratory test results Drug and Alcohol abuse information
* Diagnosis of AIDS or ARC, if applicable
* History and Physical examination
* Consultations
* Genetic testing and counseling, if applicable
* Diagnostic testing, excluding HIV testing
* Discharge summary
* Psychosocial history
* Treatment recommendations
* Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. This authorization may be revoked by me at any time except to the extent that The Stone Center of New Jersey, LLC has already acted in reliance on this authorization. This Authorization is valid for 30 days. If I revoke this authorization, I need to do so in writing and mail to: The Stone Center of New Jersey, LLC

 830 Morris Turnpike, Suite 303

 Short Hills, NJ 07078

1. I have a right to inspect the information to be disclosed.
2. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
3. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule. .

**Signature of Patient or Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If signed by a Legal Representative, name and relationship to patient:**

**Signature of Witness**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date:** **\_\_\_\_\_\_\_\_\_\_\_**