PATIENT REQUEST FOR RELEASE OF MEDICAL INFORMATION

SECTION I: PATIENT INFORMATION

Name:	Date of Birth:
Address:	Social Security #
Phone #	

SECTION II: REQUEST FOR SPECIFIC ITEMS TO BE RELEASED

I request New Jersey Healthcare Specialists d/b/a Jersey Shore Pain Management to release the medical information identified below relating to my treatment during these dates: from _____ to _____

__ Cardiovascular Reports	__ Emergency Room	__ Pathology Report	__ Consultation Report
__ History & Physical	__ Progress Note	__ Discharge Summary	__Laboratory Results
__ X-Ray Reports	__ EKG Report	__ Operative Report	__ Complete Medical Record (will n
__ Photographs, videotapes or other digital images		__ Records of Prescription Medications	

__ Other (describe):

SECTION III: DELIVERY METHOD

❑ Hold record for pick-up, I personally will claim the record	❑ Fax to this number: *(NOTE: Complete medical record will not be faxed)*
❑ Hold for pick-up by my authorized representative: Name: _____ (NOTE: Your authorized representative will be asked to produce proof of positive identification)	❑ Mail to this address:

SECTION IV: DUPLICATING FEES

I understand:

(1) There is no charge associated with having my records sent directly to another physician or provider to facilitate the continuity or transfer of my care.

(2) This request may take up to ten days to satisfy.

SECTION V: RELEASE

I hereby release New Jersey Healthcare Specialists d/b/a Jersey Shore Pain Management and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____

Signature of Patient or Legal Guardian Date