

PATIENT RECORDS REQUEST FORM

Print Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_

O Treatment dates needed for the period of \_\_\_\_\_\_\_\_\_\_\_\_thru\_\_\_\_\_\_\_\_\_\_\_\_

O A specific report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

Release records to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be: O Mailed O Faxed O Picked up

I do hereby consent to and authorize AICD to disclose to the person(s) named, information from my medical records relating to my treatment. This release is to be limited to the specified reports within the specified dates of treatment I have indicated below. I understand that this consent shall operate as a complete release of liability to AICD and to its employees for the release of information as specified below.

**I understand there will be no charge for this if the request is for less than 5 pages and $1.00 per page for over 5(five) pages. I agree to pay the charge in full at the time I receive the copy of my medical records. I understand that this request will be processed within 7-14 days except in an emergency.**

I understand that once AICD discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, AICD cannot guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. This information has been disclosed to you from records protected by Federal confidentiality rules 42C.F.R.Part2.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize AICD to use or disclose my health information in the manner described above.

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADMINSTRATIVE USE ONLY:

Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Charge:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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