**Jake Gurland, M.D.**
**523 Broadway**
**Bayonne, NJ 07002**

---

**PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION**

**Patient Name:** **DOB:**

**Jake Gurland, MD reserves the right to obtain the following: Check the appropriate boxes and include other information where indicated.**

__ Chart Notes __ Op Reports __ Discharge Summary __Entire

__ Radiology Reports __ Diagnostic Reports __ Lab Reports

Other:

_____

**This authorization will remain in effect for the duration of treatment. I have read and understand the terms of this authorization. I hereby knowingly and voluntarily authorize Jake Gurland, MD to obtain my information in the manner described above.**

_____ _____

**Signature of Patient** **Date**

_____ _____

**Signature of authorized Legal Guardian, Health Care Agent** **Date**

**Or authorized Personal Representative**

_____

**Relationship**