304 Pennington Harbourton Road
Pennington, NJ 08534
Phone: 609-293-3904
Fax: 609-739-9087

Authorization for Release of Medical Records

Patient Name:_____Date of Birth: __ / __ / __

I,_____hereby authorize the release of medical record information

To

William P. Boxer, MD
304 Pennington Harbourton Road, Pennington, NJ 08534
Phone: 609-293-3904 / Fax: 609-739-9087

From

Doctor/Clinic/Hospital: _____
Address: _____
Phone: _____
Fax: _____

Please release the following:

___ All health information (including growth charts and vaccination records)
___ History /Physical Exam ___ Discharge Summary ___Diagnostic Test Reports
___ Lab Results ___ Progress Notes ___Consultation Reports ___ Radiology/Images
___ Pathology Reports ___ Other: _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable disease and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

___ Yes, I consent to the release of this information ___ No, I do not consent
Purpose of disclosure: ___ Treatment/continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signed by: _____
Signature of Patient or Legal Guardian

Patient Name:_____ **Date: / /**