AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Name: ____
Last First Middle

Home Address: ____

____
City State Zip Code

Telephone: ______________ Alt. Telephone #: ______________ Date of Birth: ______________

PLEASE RELEASE RECORDS TO:

Name: ______________________ Organization ______________________

Address: ______________________ Phone: ______________________

______________________________________ Fax: ______________________
City State Zip

RELEASE THE FOLLOWING: *(If no date of service is provided, then only one year of records will be sent.)*

Dates of Service ________ to ________ **Provider/Specialty:** ______________

Check all boxes that apply:

☐ Abstract Record (Last year of encounters and procedures, lab results, and imaging/diagnostic result

☐ Entire Record (All records available for dates requested above)

☐ Encounters and Procedures ☐Consultation ☐Lab Results ☐Imaging/Diagnostic Results

☐ Immunization Record **Other:** ______________________________

Purpose for the Request: ☐Continuation of Care ☐Attorney/Legal ☐Insurance ☐Personal Use

Other: ____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON.

Delivery Method: ☐Mail ☐ Pick-Up

I, the undersigned authorize Nirvana Healthcare Management Services and/or business partners to release information from my medical records as described above.

Signature of Patient: ____
(If 18 years or older or is an emancipated minor)

Signature of: ____
Note: If legal guardians checked, documentation establishing relationship must be provided.

Please send the completed form to: **Nirvana Medical Records**
523 Park Avenue
Orange, New Jersey 07050
Phone: 973-672-8573 Fax: 888-412-1759