THE REHABILITATION CENTER

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This form may be completed "online". After completing the entire form print it to your local printer using the "Print Button". After printing remember to fill out the second page and then mail, fax or hand deliver to the office that you are requesting release your protected health information.

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Print Form

PATIENT INFORMATION

Patient Name:

Street Address:

City: State: Zip Code:

Date of Birth

I hereby authorize the release of my records or copies of such and request that they be transferred to:

The Rehabilitation Center, Inc.
155 Raymond Road
Princeton, NJ 08540

Office that you are requesting disclose protected health information:

Office Name:

Office Street Address:

Office City: Office State: Office Zip Code:

Please indicate the information or types of information to be disclosed:

Specify dates (or date ranges) if applicable:

This request is for the purpose of:

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and address to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authroization will expire in six months or on the following date:

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL: DO NOT RELEASE:_____

_____

Signature of Patient or Authorized Representative

_____

Print Name

Date: _____

_____

Description of Representative's Authority (witness signature required)

_____

Signature of Witness

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