Atlantic Cape OB/GYN
Specialists in Women's Health

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Informed Authorization and Consent for the release of Medical Records

I hereby authorize Atlantic Cape OB/GYN to:
( ) **RELEASE** ( ) **OBTAIN** the medical records of: ___________________________________
whose date of birth is: __________________________ and date of treatment was __________________.

( ) **RELEASE TO:**
____
____
____

( ) **OBTAIN FROM:**
____
____
____

for the purpose of: ____

Please indicate what specifically is to be released:

( ) Entire Medical Record ( ) Mammography ( ) Laboratory Tests
( ) Discharge Summary ( ) Operative Reports ( ) Pathology
( ) Other: ____

I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing, and/or HIV/ARC testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity(ies) as stated above. This authorization/consent will remain in effect for a period of one (1) year from the date stated below, unless revoked in writing by the person to which it pertains (or his/her parent, legal guardian or legally authorized agent), to the Medical Records Department. These medical records are being disclosed under the provisions of the applicable New Jersey State and Federal Law.

NOTICE TO THE RECIPIENT OF RECORDS:

This information has been disclosed to you from records protected by Federal Laws of confidentiality (42 C.F.R. Part 2). These laws prohibit you from making any further disclosure of these records, unless further disclosure is expressly permitted by written authorization by the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of these medical records is not sufficient for this purpose. You may only use these medical records for the purpose(s) as stated above.

____
Patient, Parent, Legal Guardian or Legally Authorized Agent

Dated this ____ day of _________, 20____.

____
Witness

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