Santangelo Chiropractic & Rehabilitation Center, LLC
1 Heather Dr., East Hanover, NJ 07936
973-428-8244

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Name: _____Date: _____

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize_____(name of hospital/health care provider) to release a copy of the medical information for_____(name of patient) to Santangelo Chiropractic & Rehabilitation Center, LLC @ 1 Heather Dr. East Hanover, NJ 07936 (name and address of recipient).

The information will be used on my behalf for the following purpose(s):
_____
_____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:
____All hospital records (including nursing records and progress notes)
____Transcribed hospital reports
____Medical records needed for continuity of care
____Most recent five year history
____Laboratory reports
____Pathology reports
____Diagnostic imaging reports
____Clinician office chart notes
____Dental records
____Physical therapy records
____Emergency and Urgency care records
____Billing statements
____Other

____**Please send the entire medical record (all information) to the above named recipient.**

____*HIV/AIDS-related records
____*Mental Health information
____*Genetic testing information _____ *Must be initialed to be included in other documents.
____**Drug/alcohol diagnosis, treatment or referral information: **Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

____This authorization is limited to the following treatment:
_____
____This authorization is limited to the following time period:
_____
____This authorization is limited to a worker's compensation claim for injuries of
_____ (date)/

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Date) (Signature of Patient)

_____ _____
(Date) (Signature of Legal Representative)