New Jersey Medical Experts

New Jersey Medical Experts, LLC
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Phone (732) 494-5000 · Fax (732) 494-6698
njmedicalexperts.com · Page 1 of 1

Authorization to Release Health Information

HIPAA authorization (45 CFR 164.508). Complete every section; incomplete forms cannot be processed.

Patient name (last, first)

Date of birth (MM/DD/YYYY)

1. RELEASE INFORMATION FROM

Doctor, practice or facility

Address

Phone / fax

2. RELEASE INFORMATION TO

Name of person or organization

Address or email

Phone / fax

3. INFORMATION TO BE RELEASED

- ☐ Complete medical record
- ☐ Office visit notes
- ☐ Lab results
- ☐ Imaging / radiology reports
- ☐ Medication list
- ☐ Immunization record
- ☐ Billing records
- ☐ Records from dates below only
- ☐ Other (describe below)

Dates of service (from – to), if limited

Other information (describe)

Specially protected information. New Jersey and federal law require my specific permission to release the following. Initial each one I allow; anything not initialed will not be released:

- ____ HIV/AIDS test results or treatment
- ____ Genetic testing
- ____ Mental health treatment
- ____ Substance use treatment
- ____ Sexually transmitted infections

4. PURPOSE OF THIS RELEASE

Purpose ☐ Continuing care / new doctor ☐ At my request (personal) ☐ Legal ☐ Insurance ☐ Employment ☐ Other

5. EXPIRATION

This authorization expires on (date or event). If left blank, it expires one year from the date signed.

6. MY RIGHTS

- I may **revoke** this authorization at any time by writing to New Jersey Medical Experts, LLC, Privacy Office, 1 Ethel Road, Suite 107B, Edison, NJ 08817. Revoking it does not affect information already released.
- New Jersey Medical Experts **will not condition my treatment, payment, enrollment or eligibility for benefits** on whether I sign this authorization.
- Information released under this authorization **may be re-disclosed by the recipient** and may no longer be protected by federal privacy law. Substance use treatment records covered by 42 CFR Part 2 may not be re-disclosed except as that law allows.
- I am entitled to a copy of this signed form. A reasonable, cost-based fee may apply to copies as allowed by law.

SIGNATURE

Signature of patient or personal representative

Date

If representative: authority (parent, POA...)

OFFICE USE ONLY

ID verified [ ] Copy given to patient [ ] Date sent _____ Sent by _____ Pages ____

Return this form to the front desk, or fax it to (732) 494-6698. Please bring photo ID when picking up records.

Rev. 10/2026