BCT MEDICAL ASSOCIATES

HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD.

Full Name of Patient: ____

Address:____

City: ______________________________ State: ______________________ Zip Code: _____________

Date of Birth: ___________________________________ Social Security #: ________________________

INFORMATION TO BE RELEASED:
This authorization includes release of information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol related conditions, and HIV or AIDS related conditions.

Date of service or date ranges requested ____

___Discharge summary
___History & Physical
___Face sheet
___Emergency Department Record
___Operative reports
___ Pathology reports
___ Laboratory reports
___ Immunization/shot records
___Outpatient records
___ Itemized bill
___Neuropsychological reports
___Psychological reports
___X-ray/Medical Imaging Report
___Other:
_✓_Entire medical record

THE ABOVE INFORMATION IS TO BE RELEASED TO:
BCT MEDICAL ASSOCIATES
285 Durham Avenue, Suite 1A Bld 6,
South Plainfield, NJ 07080
Fax: 908-941-5963 EFax:732-723-5332

THE ABOVE INFORMATION IS TO BE RELEASE TO:

_✓_Continued medical care
___Personal interest
___ Legal claim processing
___Insurance claim processing
___External quality/utilization review
___Other (specify) ____________________

Patient Signature____

Date: ____

Patient Guardian/Authorized Representative: ____