AUTHORIZATION TO OBTAIN PATIENT MEDICAL RECORDS & INFORMATION

Today's Date: ____________

Patient Name: ______________________________ Date of Birth: ____________

Address: ____

____

Dear Dr. ____
Print physician name from whom Valley Medical Group* is requesting the patient's medical records

____ ________ ________
Address of the physician that VMG is requesting records | Phone # | Fax #

I authorize you to disclose health information (described below) about myself or the patient named above to:

Westwood Cardiology, 333 Old Hook Road, Suite 200, Westwood, NJ 07675 | 201-664-0201 | 201-666-7970
Valley Medical Group Address | Phone # | Fax #

The type and amount of information to be disclosed is as follows:

- ☐ Problem list ☐ Medication List ☐ Immunization Record ☐ List of allergies
- ☐ Most recent history and physical
- ☐ Laboratory results for date(s) of service: ______________________
- ☐ Radiology reports/films from date(s) of service: ______________________
- ☐ Consultation reports from (please supply doctors' names) ______________________
- ☐ Entire medical record
- ☐ Entire medical record for the period ____________ to ____________
- ☐ Other (please describe) ______________________

I understand that the information in my health record from your office may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I have requested that this information be disclosed to Valley Medical Group for the following purpose(s):

- ☐ For my treatment and care
- ☐ Other: ______________________

I understand that I have the right to revoke this Authorization at any time. I understand that in order to revoke this Authorization, I must do so in writing and present my written revocation to you. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this Authorization will expire on the following date, event, or condition or in ninety days:

____________ ______________________________
Date | Event or Condition

Signature of Patient or Legal Representative: ______________________ Date: ________

If signed by Legal Representative, Name and relationship to patient: ______________________

Name and Signature of Witness ______________________

* Valley Medical Group is the "trading as" name for Valley Physician Services, Inc., Valley Medical Services, Inc., and Valley Physician Services, NY, PC