RELEASE OF INFORMATION FORM

The Advanced Spine Center

160 E. Hanover Avenue, Morristown, NJ 07960

Patient Name: _____ **Home Phone #**_____

Address: _____**DOB:** _____

Email Address:_____ **Cell Phone #** _____

Information to be disclosed:

- ☐ **Operative reports**
- ☐ **Labs/EKG**
- ☐ **Radiology Reports (MRI, CT, EMG, X-RAYS)**
- ☐ **Radiology Disc**
- ☐ **Doctor Visit Notes**

OTHER: _____

This authorization is confined to the following date of treatment:

From: _____ **To:** _____

(month/date/year) ***(Month/date/year)***

Sensitive Information: *I understand that my medical records may include information relating to sexually transmitted diseases, HIV/AIDS and related information. It may also include information about behavioral or mental health services, drug and alcohol information, tuberculosis & Hepatitis-C information.* ***I DO NOT agree to the release of such information by initialing here:***

I direct that a photocopy of this authorization be granted the same authority as the original. I understand I have the right to revoke this authorization at any time and I must do so in writing and present my written revocation to Healthmark Group. I understand the revocation will not apply to information that has already been released in response to this authorization.

Signature of Patient:_____**Date:** _____

If the patient is a minor or is otherwise unable to sign the Authorization:

Signature of Patient Representative: _____Date: _____

Description of Authority: _____

Please choose how you would like your records sent and to whom if other than patient:

EMAIL: _____

USPS MAIL: _____

FAX No.: _____

PLEASE SEND THIS REQUEST TO:

Ltarabokija@healthmark-group.com | Fax: 973-538-0909 | 160 E. Hanover Ave. Morristown, NJ 07960