HEALTHMARK GROUP

Care Station MEDICAL GROUP
RWJBarnabas HEALTH

I AUTHORIZE CARE STATION MEDICAL GROUP TO RELEASE MEDICAL RECORDS INFORMATION

PROVIDE THE PATIENT'S INFORMATION **MUST BE COMPLETED**

Name: Date of Birth: Email:

HOW WILL CARE STATION MEDICAL GROUP RELEASE THE INFORMATION **SELECT ONE OPTION**

☐ By Secure Email to Download Records ☐ By Fax ☐ By Mail

WHO/WHERE CARE STATION MEDICAL GROUP WILL RELEASE THE INFORMATION TO **MUST BE COMPLETED**

Name of the facility/person receiving the records:___________________________________

Email: Fax Number:

Address:

City: State: Zip Code:

PROVIDE THIS INFORMATION ON THE RELEASE **MUST BE COMPLETED**

Dates of Service - Please provide a copy of records **from** ______________________ **through** _________________________

Records to be Released (45 CFR § 164.508(c)(1)(i))

☐ All Medical Records (no films) ☐ Lab/Pathology Reports ☐ Last History & Physical ☐ Op Report

☐ Radiology Reports ☐ Consult Reports ☐ Other ______________________

Purpose for Disclosure

☐ Continuing Care ☐ Transfer of Care ☐ Referring Physician ☐ Disability

☐ Legal/Attorney ☐ Insurance ☐ Patient Request ☐ Other ______________________

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

☐ I understand there is a fee for patient requests and I will receive an invoice from HealthMark Group.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Signature: ____ Date: ____________________

Reason if patient is unable to sign: ____

(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)

☐ **I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above terms of use.**