PREMIER MEDICAL LAB
35-37 Progress St., #A2, Edison, NJ, 08820
Phone: 908-754-4300 Fax #: 908-754-4301

Medical Record release form

Patient name_____ **DOB:**_____

Person(s)/entity requesting medical records_____

Home phone #_____ **Cell phone #** _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical record, or summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV/AIDS: I DO____ DO NOT____ consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any causative agent of AIDS with the test of my medical records. Initials:_____ **Date:**_____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

_____

Release my protected health information to the following person(s)/entity:

Name:_____

Street:_____**City:**_____

State:_____**Zip:**_____

I DO____ DO NOT____ give permission for these health records to be faxed or sent by e-mail, mail to the above entity.

The reasons for this release of information are as follow_____

_____

_____

_____

Patient Signature (or parent, guardian or legal representative)_____

Date:_____

- ❑ **I understand that you will provide this information within 15 days from receipt or request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the New Jersey State Board of Medical Examiners.**