Medical Records Release Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1) PATIENT INFORMATION:

_____ _____ _____
Patients Name Date of Birth Phone Number

_____
Address City State Zip

2) AUTHORIZES: Ventnor Wellness / Robert Michael Grife Enterprises / Jared Mannello, LLC
Name of Medical Office

6601 Ventnor Avenue, Suite 105, Ventnor City, NJ 08406 (609) 350-6680 (609) 317-4868 katiea1.vw@gmail.com
Address Phone Fax Email

3a) TO DISCLOSE TO : _____
Name of Healthcare Provider / Plan / Other

_____(_____)_____(_____)_____
Address Phone Number Fax Number

□ Self / Delivery Options: □Pick up □ Mail to address above

□ To be picked up: I hereby authorize:_____ to pick up my records. (Photo ID required.)

3b) TO OBTAIN FROM: _____
Name of Healthcare Provider / Plan / Other

_____ (_____)_____ (_____)_____
Address Phone Number Fax Number

4) DATE(S) OF INFORMATION TO BE DISCLOSED/OBTAINED: From _____ to _____
**If left blank, only information from the past two (2) years will be disclosed/obtained. (month/year) (month/year)

5) INFORMATION TO BE DISCLOSED/OBTAINED:

□Complete Medical Record □Specific records/information as follows: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED/OBTAINED (as defined by applicable state and federal laws):

□Alcohol/Drug Abuse □HIV Test Results □ Mental Health / Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date / event: _____

Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) PURPOSE (Check all that apply - copy fees may apply)

□Transfer of Care □ Coordination of Care □Personal (at my request) □Other: _____

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying Ventnor Wellness in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) SIGNATURE OF PATIENT / LEGAL REP: _____ DATE: _____

If signed by a person other than the patient, complete the following:

1. Individual is: □a minor □legally incompetent or incapacitated □deceased
2. Legal authority: □ parent □legal guardian □next of kin / executor of deceased □activated POA for Health Care