

UROLOGY CARE OF CENTRAL NEW JERSEY, P.A.

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Authorization For Release of Medical Information

I, _____ authorize _____
To release the following medical information _____

(Please initial appropriate box)

_____ Any and all of my Medical record (as of the date of this release);
_____ Any and all of my Medical record except the following:

This release also specifically allows the release of the following information (this information will not be released unless the appropriate box is initialed);

_____ Any record of treatment for drug and/or alcohol dependency or abuse;
_____ Any record of mental health treatment;
_____ Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

This information is being released for the following purpose(s) only:

_____ and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective for six months from date of execution; however, it may be revoked by me at any time by providing notice in writing to the above named party.

Signature _____ Date _____