Peter Wenger, MD
Richard Levandowski, MD
Cara Barlis, MD

Denise Wunderler, DO
Lauren Eisenhauer, APN

3131 Princeton Pike Bld. 4A, Suite 100
Lawrenceville, NJ 08648
P: (609) 896-9190 F: (609) 896-3555

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby authorize the use and disclosure of my health information. I understand this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient. This form is only valid when filled out completely by the patient.

PATIENT NAME: ____

DATE OF BIRTH: ____

RELEASE THE MEDICAL INFORMATION:

(CIRCLE ONE) **TO** **FROM**

NAME OF PERSON: ____

ORGANIZATION: ____

ADDRESS: ____

CITY, STATE, ZIP: ____

PHONE NUMBER: ____

FAX NUMBER: ____

* Please allow 30 days for your medical records to arrive at their requested location. *

Please Initial if Allowed:

______ I consent to the release of sensitive medical information, up to and including psychological treatment, drug and alcohol treatment, and/or HIV treatment.

I also understand that:

- Federal privacy regulations will no longer apply to the information disclosed.
- A copy of this authorization may be utilized with the same effectiveness as an original.
- This authorization will expire **one year** from the date of the signature.
- I understand I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the proper letter is received.

____ ______________

PATIENT/PARENT/GUARDIAN SIGNATURE DATE