Monmouth Family Health Center, Inc

☐ **Monmouth Family Health Center**
Medical/Pediatrics/Podiatry/Health Behavior
270 Broadway
Long Branch, NJ 07740
Phone: (732) 923-7100
Fax: (732) 923-7104

☐ **Woman's Wellness Center of**
Monmouth Family Health Center
OB/GYN Services
80 Pavilion Avenue
Phone: (732) 963-0114
Fax: (732) 229-0266

☐ **The Dr. Barry Elbaum**
Dental Center at
Monmouth Family Health Center
335 Broadway
Long Branch, NJ 07740
Phone: (732) 475-3800
Fax: (732) 483-6444

Patients Name: _____

Address: _____

Telephone: _____ **D.O. B**: _____

Records Requested Out:

I authorize the Monmouth Family Health Center to Disclose my health information to:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

Records Requested by MFHC:

The above patient is currently being treated by MFHC and this information is needed as soon as possible for continuing medical care.

Name: _____

Address: _____

Phone#: _____

Fax #: _____

This authorization is limited to the following dates and treatment: From: _____ **To**: _____

Information to be disclosed:

_____ **IMMUNIZATION RECORD**
_____ **PROGRESS NOTES**
_____ **ORDERS NOTES**
_____ **DENTAL XRAYS**
____ **LAB RESULTS ONLY**
____ **MEDICATION LIST**
____ **CONSULTATION REPORTS**
____ **DENTAL RECORDS**
____ **COMPLETE RECORD**
____ **BILLING INFORMATION**
____ **PROCEDURE NOTES**
____ **OTHER – SPECIFY** _____
_____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including REPRODUCTIVE RIGHTS, TUBERCULOSIS AND OTHER INFECTIOUS DISEAS information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Monmouth Family Health Center. I understand the revocation will not apply to the extent that the Monmouth Family Health Center has already taken action in reliance on this authorization. This authorization will automatically expire in 120 days from the date of the signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or enrollment or eligibility in benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Monmouth Family Health Center at (732) 923-7100.

PATIENT/GUARDIAN NAME: _____ **DATE**: _____

PATIENT/GUARDIAN SIGNATURE: _____

_____

If legal representative, sign below and state relationship and authority to do so and attach the document of authority

LEGAL REPRESENTATIVE: _____ DATE: _____

RELATIONSHIP: _____

WITNESS: _____ DATE: _____

COPY OF AUTHORIZATION TO PATIENT