BCD Health Partners

160 Pehle Avenue, Suite 302
Saddle Brook, NJ 07663

TEL: (201) 252-8700
FAX: (201) 252-8701

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship: _____ Phone: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Healthcare information identifies you (the patient) by name and includes other demographic information about you.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and or psychiatric diagnoses complied during my visit, encounter or hospitalization or make copies thereof in accordance with the policies of this facility.

This authorization will automatically expire 1 year after the date below (except where indicated) unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Guardian/
Patient Signature: _____ Date
Signed: _____

THIS AUTHORIZATION WILL EXPIRE 1 YEAR AFTER IT IS SIGNED.