Princeton Endocrinology Associates, LLC.

10 Forrestal Road South; Ste 106
Princeton, NJ 08540

941 Whitehorse-Mercerville Road; Ste 11
Hamilton, NJ 08619

Main Telephone Number: (609) 921-1511

Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I hereby authorize _____to release my health information as described below to:

Recipient Name:

Recipient Complete Address:

Recipient Telephone Number:

Documents/Information to be released:

____ Laboratory Tests ____ Physician Letters

____ Progress Notes ____ Other_____

Purpose of disclosure:

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (HIPAA) govern the terms of this authorization. I understand that I have the right to revoke this authorization at any time prior to the practice compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke a description of how I may revoke this authorization is set forth in the Practice Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature and that I should send it to the office.

I understand that I am required to sign this authorization and that the practice may not condition treatment on my execution of this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires upon the practice's release of the information described above or 30 days after the date of authorization, as set forth below, whichever comes first.

I understand that I must provide a minimum of 24 hours notice to this practice to provide adequate time for record copying. I recognize that a fee as designated by the state of New Jersey will apply to obtaining my record copies.

I hereby acknowledge receipt of a copy of this authorization.

_____ _____

Signature of Patient or Guardian Date