Authorization For Release of Health Information Pursuant to HIPAA

Momentum Medicine Plus, LLC

Phone: 856-552-2208 Fax: 856-283-3158

113 West White Horse Rd
Voorhees, NJ 08043

309 Creek Crossing Blvd
Hainesport, NJ 08036

Examinee Name:	**Date of Birth: / /**	
Examinee Address: _____		
City:_____ State:____ Zip Code:_____		

I, or my authorized representative, request that the health information regarding my care and treatment as set forth in this form:

1.This authorization may include the release and disclosure of all medical information and records including but not limited to Alcohol and Drug Abuse, Mental Health Treatment, and confidential HIV related medical information only if I initial the appropriate box or boxes below. I understand that the records may include personal information included but not limited to name, address, phone number(s), and social security number. In that case, I specifically authorize this information to the person or company as indicated below.

2. If I am authorizing the release of HIV related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV information without authorization.

3. I have the right to revoke this authorization at any time by writing to the healthcare provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5.Information disclosed under this authorization might be re-disclosed by the recipient

6. Name of health Care provider or Company to release information: **Momentum Medicine Plus LLC**

7. Name of Provider/person/Company to whom this info will be sent to:_____

Address:_____ Phone:_____ Fax:_____

8. Information to be released:

a.□ Medical Record(s) from:_____ to _____

b.Entire Medical records, including patient histories, office note, test results, radiology studies/reports, referals, consults, billing records, insurance records, and records sent to you by other health care providers

c.□ Following individual information:

□ Entire Medical Record □ Health Care Billing Statements □ Pathology Reports □EKG □ Progress Notes
□ Laboratory Reports □Operative Reports □ All Radiology Reports (xrays, CT, MRI, Bone Scans,etc) □Diagnostic Imaging Reports □Diagnostic Reports (NCV/EMG, EEG,etc) □ NCV/EMG □ ER reports □ History & Physical Exams
□ Consultations □Outpatient Clinic Reports □Psychiatric Tests

d. I authorize the following information to be released also if I put my initials on the lines:

□**_____** I agree to the release of information to drug & alcohol abuse, diagnosis, or treatment
□_____ I agree to the release of information pertaining to mental health diagnosis and treatment
□_____ I agree to the release of HIV/AIDs testing information

e. Authorization to Discuss Health Information:

I authorize: Momentum Medicine Plus LLC and all its associates and employee's to discuss my health information with my attorney, governmental and state agency, and NJ DDS and their physicians and employee's.

All items on this form have been completed and my questions about this form have been answered.

Signature of examinee :_____ Printed Name:_____ Date:___/___/2014

Witness Signature:_____ Printed Name:_____ Date:___/___/2014

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