

**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

<b>Examinee Name:</b> _____	<b>Date of Birth:</b> /    /	
<b>Examinee Address:</b> _____		
<b>City:</b> _____	<b>State:</b> _____	<b>Zip Code:</b> _____

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

<b>6. Name of health Care provider or Company</b> to release information: <b>Momentum Medicine Plus LLC</b>
<b>7. Name of Provider/person/Company</b> to whom this info will be sent to: _____
<b>Address:</b> _____ <b>Phone:</b> _____ <b>Fax:</b> _____
<b>8. Information to be released:</b>
<b>a.</b> <input type="checkbox"/> <b>Medical Record(s) from:</b> _____ <b>to</b> _____
<b>b.</b> <b>Entire Medical records, including patient histories, office note, test results, radiology studies/reports, referrals, consults, billing records, insurance records, and records sent to you by other health care providers</b>
<b>c.</b> <input type="checkbox"/> <b>Following individual information:</b>
<input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Health Care Billing Statements <input type="checkbox"/> Pathology Reports <input type="checkbox"/> EKG <input type="checkbox"/> Progress Notes
<input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Operative Reports <input type="checkbox"/> All Radiology Reports (xrays, CT, MRI, Bone Scans, etc) <input type="checkbox"/> Diagnostic Imaging Reports <input type="checkbox"/> Diagnostic Reports (NCV/EMG, EEG, etc) <input type="checkbox"/> NCV/EMG <input type="checkbox"/> ER reports <input type="checkbox"/> History & Physical Exams
<input type="checkbox"/> Consultations <input type="checkbox"/> Outpatient Clinic Reports <input type="checkbox"/> Psychiatric Tests
<b>d. I authorize the following information to be released also if I put my initials on the lines:</b>
<input type="checkbox"/> _____ I agree to the release of information to drug & alcohol abuse, diagnosis, or treatment
<input type="checkbox"/> _____ I agree to the release of information pertaining to mental health diagnosis and treatment
<input type="checkbox"/> _____ I agree to the release of HIV/AIDs testing information
<b>e. Authorization to Discuss Health Information:</b>
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

This facsimile may contain information covered under the Privacy Act, 5 USC 552(a) and/or the Health Insurance Portability and Accountability Act (PL 104-191) and it's various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this facsimile contains healthcare information ,it is being provided to you after appropriate authorization from the patient/examinee or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient/examinee consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality subjects you to application of appropriate sanction.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distributions, or reliance upon the contents of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone so that we can arrange the return of the transmittal at no cost to you. Thank you. Momentum Medicine Plus, LLC.