Dr. Dashevsky, Dr. Hossain, Dr. Altshuler and Dr. Ghosh

256 Bunn Drive, Suite 3A

Princeton, NJ 08540

(609) 683-7773

FAX (609) 683-7958

HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient name: _____ Date of Birth: _____

Previous name: _____

AUTHORIZATION TO RELEASE MEDICAL RECORD:

You may use or disclose the following health care information (check all that apply):

All health care information in my medical record _____

Health care information in my medical record relating to the following treatment or condition

_____

Health care information in my medical record for the dates(s): _____

Other (e.g., x rays, bills), specify date(s): _____

You may use or disclose the following health care information regarding testing, diagnosis, and

treatment, should it be found in my records, **only** if checked below:

HIV (AIDS virus) _____Sexually transmitted diseases_____

Psychiatric disorders/mental health____ Drug and/or alcohol use_____

You may disclose this health care information to:

MEDICAL ASSOCIATES OF PRINCETON, LLC

ELENA ALTSHULER, INC

256 Bunn Drive, Suite 3A

Princeton, NJ 08540

(609) 683-7773

FAX (609) 683-7958

REQUIRED:

I will stop being a patient effective_____

I will still continue to be a patient_____ This authorization ends: On (date): _____

When the following event occurs: _____

In 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient

for purposes other than payment)

By signing below I acknowledge and understand my rights that have been given to me.

_____
_____

Patient or legally authorized individual signature **Date/Time**

_____
_____

Printed name if signed on behalf of the patient **Relationship (parent, legal guardian)**