ELENA ALTSHULER, INC.
256 BUNN DRIVE SUITE 3A, PRINCETON, NJ 08540
PHONE: 609-683-7773 FAX: 609-683-7958

HIPAA CONSENT TO RELEASE MEDICAL INFORMATION

PATIENT: _____ BIRTHDATE: _____

PHYSICIAN RELEASEING RECORDS:

NAME: _____

ADDRESS: 256 BUNN DRIVE STE 3A

CITY/STATE/ZIP: PRINCETON, NJ 08540

PHONE: _____ FAX: _____

PHYSICICAN/PERSON TO RECEIVE RECORDS:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ FAX: _____

_____ENTIRE MEDICAL RECORDS, **INCLUDING,** Information related to the treatment for substance abuse or dependency; Psychiatric or mental health treatment; Information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Entire medical record, **EXCLUDING**, related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; Information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

This applies to all Information In my medical record protected under the regulation in 42 codes of Federal Regulations', part 2.

I authorize medical Information to be released as Indicated above. I understand this release Is effective until _____, but that I may revoke my consent at any time providing written consent to the above-named party.

TRANFER TO ANOTHER DOCTOR (PLEASE CIRCLE): YES AS OF: _____

Any patient who Is 18 years of age and older must sign unless proof of a legal power of attorney Is provided showing patient is medically Incompetent to sign on behalf of themselves.

_____ _____ _____

Print Patient/Patient's Legal Guardian Name Patient's Signature/Legal Guardian Date:

Disclaimer: Our office will provide a *one-time* courtesy copy of you/your child's records. Any additional records needed after the courtesy copy will have a charge of $1 per page of the record needed; by signing above you agree to the terms of this agreement.