AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian and returned. There may be a processing fee associated with this request.

AS YOU COMPLETE EACH STEP ON THE FORM,
PLEASE MAKE CHECK MARK IN THE BOX PROVIDED AT LEFT

Step 1 Completed	**STEP 1: Information About You:** PLEASE PRINT! Patient Name: _____ Date of Birth: ____/____/____ Last First Address: _____ Street City State Zip
Step 2 Completed	**STEP 2: Who has the records now?** PLEASE PRINT! I hereby authorize: _____, M.D./D.M.D. (circle one) Physician's _____ Address _____
Step 3 Completed	**STEP 3: To whom do you wish to release your records?** PLEASE PRINT! To release the following information, please specify: ALL RECORDS OR Dates of Treatment: _____ Other: _____ TO: _____, M.D./D.M.D. (circle one) _____ _____
Step 4 Completed	**STEP 4: Your signature** This authorization is good for 90 days and may be revoked at any time in writing prior to the expiration date Additional authorization for disclosure beyond recipient is required. _____ Patient's Signature _____ _____ Witness Signature Parent/Guardian's Signature
Step 5 Completed	**STEP 5: Release for Sensitive Information:** I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, veneral disease, social service, Hepatitis B testing/treatment, I agree to its release. _____ _____ Signature of Patient or Legal Guardian Date
Step 6 Completed	**STEP 6:** In addition to the above signatures, if you want your HIV (AIDS) testing/treatment records released you must sign and date on the line below. _____ _____ Signature of Patient or Legal Guardian Date
Step 7 Completed	**STEP 7: Authorization to Release Genetic Information:** In addition to the signatures above, if you want your genetic information records released, you must sign and date on the line below _____ _____ Signature of Patient of Legal Guardian Date
Step 8 Completed	**STEP 8: Authorization to speak with Representatives** In addition to the above signatures,I authorize _____ to speak with my legal representative, _____, concerning my medical information. _____ _____ Signature of Patient Date

Please drop this form off at any of our office locations, or fax to our Medical Records Department at (609) 924-3477 or mail to Princeton Medical Group, PA, Medical Records Department, 419 North Harrison Street, Princeton, NJ 08540. Depending on request details, we reserve the right to request a mailed original signature.