Nirvana Healthcare

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____

_____
City State Zip Code

Telephone: _____ Alt. Telephone #: _____ Date of Birth: _____

PLEASE RELEASE RECORDS TO:

Name: _____ Organization _____

Address: _____ Phone: _____

_____ Fax: _____
City State Zip

RELEASE THE FOLLOWING: (If no date of service is provided, then only one year of records will be sent.)

Dates of Service _____ to _____ **Provider/Specialty:** _____

Check all boxes that apply:

☐ Abstract Record (Last year of encounters and procedures, lab results, and imaging/diagnostic result

☐ Entire Record (All records available for dates requested above)

☐ Encounters and Procedures ☐Consultation ☐Lab Results ☐Imaging/Diagnostic Results

☐ Immunization Record **Other:** _____

Purpose for the Request: ☐Continuation of Care ☐Attorney/Legal ☐Insurance ☐Personal Use

Other: _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON.

Delivery Method: ☐Mail ☐ Pick-Up ☐ Fax

I, the undersigned authorize Nirvana Healthcare Management Services and/or business partners to release information from my medical records as described above.

Signature of Patient: _____ **Date:** _____
(If 18 years or older or is an emancipated minor)

Signature of: _____
Note: If legal guardians checked, documentation establishing relationship must be provided.

Please send the completed form to:

Nirvana Medical Records
523 Park Avenue
Orange, New Jersey 07050
Phone: 973-672-8573 Fax: 888-412-1759