advocare | Center for Specialized Gynecology

Authorization For Release of Patient Records – Fax to 856-424-0704

Name: _____ Date: _____
Address: _____
Phone #: _____ DOB: _____

I authorize Advocare Center for Specialized Gynecology to disclose to:

New Office: _____
Address: _____
Fax: _____

[ ] ALL medical records from Advocare Center for Specialized Gynecology

[ ] Medical records to the following extent:

_____
_____

Reason for disclosure:

_____

I understand that if my medical records contain information related to the history, diagnosis and/or treatment of any psychiatric problem, mental illness, drug abuse, alcoholism, sexually transmitted or communicable diseases, AIDS, or test for infection with human immunodeficiency virus (HIV), or tests for genetic diseases, including DNA tests, that my signing this document authorizes Advocare Center for Specialized Gynecology to release that information. I acknowledge and am aware that New Jersey has statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege, except as specified above.

This consent may be revoked at any time by writing to Advocare Center for Specialized Gynecology, except to the extent that records have already been released in reliance on this form. This consent otherwise will expire 90 days after the dated signature below.

I acknowledge and understand that uses and disclosure of my health information authorized by this document may be subject to re-disclosure by the recipient and may not be protected by privacy and confidentiality laws.

Signature of patient or guardian: _____Date: _____

Please return the completed form to our office. Note that there may be a charge for copies per state Medical Society guidelines. If so, a staff member will contact you to review any charges.

Susan Kaufman, DO, FACOG • Jodi Benett, DO, FACOOG
Helen Gorlitsky, MD, FACOG • Faith Tiver-Foran, MSN, WHNP-BC