David Sikowitz M.D.

55 North Gilbert Street
Suite 2203
Tinton Falls, New Jersey 07701

(732) 740-7675 Telephone
(732) 842-0100 Fax
www.thetmscenterofnj.com

Authorization to Release or Obtain Protected Healthcare Information

Patient Name: ____

Birth Date: _____/_____/_____

Previous Names: ____

Social Security #:_______/_______/_______

Address: ____

City, State & Zip Code: ______________________________ Phone #:______________________________

I request and authorize Dr. David Sikowitz to release or obtain healthcare information concerning the patient identified above, in accordance with state and federal laws, to the following:

____.

Name/Organization to Receive or Send Information

____

Address City, State, Zip Code and Phone Number

1. **Specific information to be disclosed** (check all that apply or describe the information)

Discharge Summary   Psychiatric Evaluations   Progress Notes   Substance Abuse

History & Physical Examination   Medical conditions   Lab Reports   Radiology/X-ray Reports

Consultation Reports

Other: ____

2. With the exception of psychotherapy notes, I authorize all information which may be contained in my medical records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released unless otherwise specified here:

____

3. I am requesting this information be released for the following purpose:

Continued Care Consultation Insurance Claim Personal Use Attorney Review

Other ____

4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

5. I understand there may be a fee to process this release of information.

6. This authorization will automatically expire on: _______/_____/______ or one year from the date of my signature.

7. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving Party any may no longer be protected by Federal or State Law, unless protected by Federal Regulation 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the receiving Party without my written authorization.

8. I hereby agree to indemnify and hold Dr. David Sikowitz, and employees of The TMS Center of New Jersey free and harmless from any actions against them for alleged invasion of privacy, libel, slander, or defamation arising from or related to disclosure of such information.

____________________________________ ____________________________________

Patient or Patient's Legal Representative's Signature **Print Legal Representative's Name & Relationship*

Date ____________________ *Witness* ________________________________

REASON PATIENT IS UNABLE TO SIGN:

Minor Deceased Other: ____

AUTHORITY ATTACHED (In non-emergency situations documentation of legal representative's authority to sign for the patient must be included).